

UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF IOWA  
CENTRAL DIVISION

KARA McGEE,

Plaintiff,

vs.

JO ANNE B. BARNHART,  
Commissioner of Social Security,

Defendant.

No. C02-3042-PAZ

MEMORANDUM OPINION  
AND ORDER

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***APPENDIX A - MEDICAL RECORDS SUMMARY***

## ***I. INTRODUCTION***

The plaintiff Kara McGee (“McGee”) appeals a decision by an administrative law judge (“ALJ”) denying her Title II disability insurance (“DI”) benefits. McGee argues the ALJ erred in (1) improperly discounting her treating physicians’ functional capacity assessments; (2) failing to make a proper *Polaski* analysis; and (3) relying on a faulty hypothetical question. McGee argues that because of these errors, the Record does not contain substantial evidence to support the ALJ’s decision denying her claim for benefits. (*See* Doc. No. 14)

## ***II. PROCEDURAL AND FACTUAL BACKGROUND***

### ***A. Procedural Background***

On November 30, 1998, McGee filed an application for DI benefits, alleging a disability onset date of November 1, 1998. (R. 30, 150-52) The application was denied initially and on reconsideration. (R. 135-36, 137-40, 143-47)

McGee requested a hearing, and a hearing was held before ALJ John P. Johnson in Waterloo, Iowa, on May 3, 2000. (R. 67-116) Attorney Richard Vickers represented McGee at the hearing. McGee testified at the hearing, as did Delores Gray White, Jennifer Sue Keeling, and Vocational Expert (“VE”) Steven Moats. On November 16, 2000, the hearing was reconvened to take testimony from Paul From, M.D., and additional testimony from McGee. (R. 117-134)

On April 18, 2001, the ALJ ruled McGee was not entitled to benefits. (R. 27-41) On June 7, 2001, McGee requested review by the Appeals Council (R. 21-22), and on April 12, 2002, the Appeals Council denied McGee’s request (R. 9-10), making the ALJ’s decision the final decision of the Commissioner.

McGee filed a timely Complaint in this court on June 26, 2002, seeking judicial review of the ALJ's ruling. (Doc. No. 3) On September 9, 2002, the parties consented to jurisdiction by the undersigned United States Magistrate Judge, and Chief Judge Mark W. Bennett transferred the case to the undersigned. (Doc. No. 6) McGee filed a brief supporting her claim on February 27, 2003. (Doc. No. 14) On April 21, 2003, the Commissioner filed a responsive brief. (Doc. No. 18) The court now deems the matter fully submitted, and pursuant to 42 U.S.C. § 405(g), turns to a review of McGee's claim for benefits.

## ***B. Factual Background***

### ***1. Introductory facts and McGee's daily activities***

At the time of the hearing, McGee was a 38-year-old widow living in Clarksville, Iowa. (R. 71) She was 5'2" tall, and weighed 220 pounds. (R. 85) She had a valid, unrestricted driver's license, and drove about 150 miles each week. (*Id.*)

In 1986, she received her G.E.D. (R. 71) She also received some training to be a nurse's aide, but worked as a nurse's aide for only about two weeks. (R. 72) For the remainder of her fifteen-year employment history, she provided child care to as many as ten children at a time. (*Id.*) Because of health problems, for the eighteen months preceding the ALJ hearing, McGee cared for just two children, and McGee's mother and a neighbor helped watch them because McGee was not able to watch them on her own. (R. 72, 76-77) She received \$60 per week for watching the children. (R. 79-80) One of the children was seven months old, and the other was three-and-one-half years old. (R. 78)

McGee explained that she had an ileostomy in 1978, when she was about 16 years-old. (R. 73, 87) About four years before the hearing, she developed insulin-dependent

diabetes. (R. 73, 88) She also has arthritis, and she recently discovered she has “liver failure.” (R. 73) She has migraine headaches two or three times a week, but takes medicine to control the condition.<sup>1</sup> (R. 74, 88) She also suffers from depression. (R. 74) In the past, she has had carpal tunnel syndrome. (R. 75) She suffers from ulcerated colitis, or Crohn’s disease. (R. 79, 89) She also has had her gall bladder removed. (R. 79)

McGee testified that she spends about a day-and-a-half each week in doctors’ offices, emergency rooms, and hospitals. (R. 76) She frequently suffers from dehydration, and has had a port installed in her chest so she can receive intravenous fluids more easily. (R. 82-83) Shortly before the hearing, she had a procedure where they injected her spine to treat pain in her back and hips. (R. 81) She also had another procedure where her doctor cleaned out a pocket of pus that had formed at her rectum, a recurring side-effect of her ileostomy. (R. 82)

McGee described her typical day as follows. She gets up in the morning between 7:00 a.m. and 7:30 a.m. (R. 93) She eats breakfast, and then spends the morning watching television with the two children she cares for. (R. 94) The children then have lunch. She puts them to bed for a nap at about 1:00 p.m. (*Id.*) While the children are napping, McGee usually lies down with them. (R. 77, 94) The children ordinarily sleep until someone picks them up, between 3:30 p.m. and 4:00 p.m. (R. 94) After the children leave, McGee cleans up the house if she feels up to it, and then cooks supper, does the dishes, and watches television. (R. 95) She attends church every Sunday. (*Id.*)

McGee’s ostomy runs continuously, and she has to empty the bag about twenty times a day. (R. 77) It takes her five to ten minutes to empty the bag. (*Id.*) McGee is

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<sup>1</sup>She testified that when she feels a migraine headache coming on, she takes the medication and lies down in her room for twenty minutes to an hour, and the headache usually goes away. (R. 88)

unable to stand on her feet for long periods of time because of pain in her hips and back. (*Id.*) When asked if she can lift the children she watches, she testified she can lift the baby, who weighs sixteen pounds, but she cannot lift the older child. (R. 78, 91) Sometimes she can do housework, but other times she cannot do anything. (R. 78) She goes to bed at about 8:30 p.m., but has problems sleeping. (R. 93-94)

McGee can walk about three or four blocks at a time, until her hips start hurting. (R. 90) She can stand for about twenty minutes at a time. (*Id.*) Her knees give her problems when climbing stairs, bending, stooping, kneeling, or squatting. (*Id.*) Her hands go to sleep if she writes for more than a half hour. (R. 90-91) She can sit for “a couple hours.” (R. 91) Her back hurts when she reaches her arms over her head. (R. 92) She has some difficulty remembering things. (*Id.*) When faced with stress, she cries easily. (*Id.*)

At the time of the hearing, McGee was taking the following medications on a daily basis: opium and liquid potassium, for ostomy maintenance; Celebrex, for arthritis; Neurotin, for diabetic neuropathy; Paxil, for depression; Prevacid, for ulcers; Demadex, as a “water pill;” Propranolol, for blood pressure and migraines; Trazodone, as a sleeping pill; Insulin N and Humalog, for diabetes; Zyrtec and Flonase, for allergies; Buspar, for anxiety; and non-prescription magnesium, Metamucil, and aspirin. (R. 74-75; 221) She also was taking Imitrex, on an as-needed basis, for migraines. (R. 75)

McGee’s mother, Delores Gray White, also testified at the hearing. At the time of the hearing, White had been living with McGee for about one year. (R. 95-96) White had moved in with McGee after McGee’s husband had died, and because both White and McGee are disabled, they decided they could help each other. (R. 96) White believes McGee is “goin’ down hill, quite a way.” (*Id.*) White testified that both she and her daughter work together to care for the children. (R. 97)

McGee also called Jennifer Sue Keeling, an acquaintance, as a witness at the hearing. (R. 99) Keeling has known McGee since 1993. (R. 100) At the time of the hearing, McGee was babysitting for Keeling's two youngest children. (*Id.*) Keeling testified that about once a week, she has to find alternative childcare arrangements for her children because McGee is having physical problems. (*Id.*) According to Keeling, McGee is not physically capable of caring for more than her two children. (R. 104) In order to keep her two children with McGee, Keeling makes many allowances that most parents would not make. (R. 106-07)

## **2. McGee's medical history**

A detailed chronology of McGee's medical history is attached to this opinion as Appendix A. The earliest medical documentation in the Record relating to her claim of disability is a March 1997 report of a hospitalization for dehydration at the Waverly Municipal Hospital. (R. 223-39) McGee gave a history of a permanent ileostomy secondary to a total colectomy for ulcerative colitis. (R. 223) She came to the hospital because she had lost large volumes of fluid through her ileostomy and from vomiting. (R. 225) Her condition was brought under control after a three-day hospitalization. (*Id.*)

Later in March 1997, McGee again was seen at the Waverly Municipal Hospital, for Type I insulin dependent diabetes mellitus. (R. 241) She was referred for self management education. (*Id.*)

In April 1997, McGee was admitted to the Waverly Municipal Hospital for two days for "dumping syndrome and dehydration." (R. 246) Her condition was brought under control with IV fluids. (*Id.*) She was hospitalized again in July 1997, for the same problem. (R. 255) In the records of that hospitalization, her diabetes is described as Type II, controlled with diet and oral medication. (*Id.*) She was discharged after two

days, but a day later she was readmitted for three days because of weakness and severe diarrhea. (R. 263)

On August 22, 1997, McGee was seen at the hospital for headaches and dizziness. (R. 265) A CT scan of her head was negative. (R. 267)

McGee was hospitalized for dehydration on September 9, September 28, and December 31, 1997, and January 1, 1998. On January 22, 1998, she was seen by Dawn Morey, D.O. for complaints of abdominal pain. (R. 293) Dr. Morey observed lesions on the periphery of McGee's stoma, and ordered an upper GI panendoscopy with biopsy. (*Id.*) The test was performed, and Dr. Morey determined that McGee had a gastric ulcer and small papilloma on her stoma, and gastroparesis. (R. 289) McGee saw Dr. Morey again on January 26, 1998. (R. 493) On January 28, 1998, Dr. Morey performed an endoscopy, and diagnosed McGee as suffering from a lymphoid hyperplasia in the small bowel. (R. 298)

On February 3, 1998, McGee went to the hospital complaining of "dramatic diarrhea with dehydration." (R. 309) On February 4, 1998, she had an abdominal X-ray, and it appeared she had a partial small bowel obstruction. (R. 305) This diagnosis was supported by a CT scan on February 5, 1998. (307) On February 20, 1998, a revision of ileostomy surgery was performed on McGee to open up her small bowel. (R. 310-13) After the surgery, McGee developed an allergic reaction to the stoma appliance, but the reaction resolved after treatment. (R. 491-93)

On April 27, 1998, McGee was seen for right leg pain by Lee O. Fagre, M.D., at the Waverly Municipal Hospital. (R. 314-16) A CT scan showed mild to moderate degenerative changes in her lower spine, with no herniations but some bulges, most prominently at L4-5 and L5-S1. (R. 316)

On March 8, 1998, McGee was admitted to the hospital complaining of marked output from her ileostomy and dehydration. (R. 317) She was hospitalized for three days, and treated with intravenous fluids and antibiotics. The final diagnosis was gastroenteritis with marked output from ileostomy causing dehydration, leukocytosis, urinary tract infection, non-Insulin-dependent diabetes mellitus, hypertension, hyperlipidemia, and gastroesophageal reflux disease. (R. 317) On June 19, 1998, McGee was admitted to the hospital for three days because of chronic dumping syndrome, with secondary dehydration and underlying abdominal pain. (R. 341) Drs. Morey and Fagre decided to refer McGee to the University of Iowa Hospitals and Clinics for a consultation. (*Id.*)

On July 6, 1998, McGee was seen at the Center for Digestive Diseases at the University of Iowa. (R. 355-59) In a report, Robert W. Summers, M.D., a doctor with the Center, recited the following medical history:

[McGee's] past medical history is significant for a history of ulcerative colitis since the 1970s. The disease required colectomy, ileostomy and later revision of the ileostomy in February of 1998; history of adult diabetes mellitus since April of 1995; history of obesity; history of hypertension since February of 1996; history of hyperlipidemia.

(R. 355) Dr. Summers made the following assessment:

Intermittent crampy abdominal discomfort with high ostomy output. At this time based upon her history of multiple abdominal surgeries for her Crohn's disease, there was a concern that the patient may have recurrent bowel obstruction. Thus, the patient has been scheduled for a small-bowel series. These tests will help us rule out Crohn's disease as well as to evaluate for possible evidence of a bowel obstruction. In the meantime, the patient was encouraged to force fluids. Interestingly to note, the patient's electrolytes obtained yesterday were all within normal limits.

(R. 356) The findings from an “upper G.I. with small bowel series” were “suggestive of gastritis and prior ulcer disease. No active Crohn’s disease identified. No evidence for stricture.” (R. 357) A gastrointestinal endoscopy indicated “normal ileoscopy without evidence of inflammatory bowel disease or stenosis.” (R. 358) A biopsy of the ileum was normal. (R. 359)

On July 12, 1998, McGee went to the Waverly Municipal Hospital, complaining that she felt weak and clammy. (R. 360) The following day, she returned, complaining of leg cramps. (R. 419) She went to her doctor complaining of anxiety, dehydration, and bowel problems on July 15, 21, and 27, August 5, 14, and 27, and September 3, 1998. (R. 415-18) She was hospitalized on September 3, 1998, for more aggressive therapeutic intervention, including the administration of IV fluids. (R. 375) The assessment of Joseph Berdecia, M.D. was “probable transient viral gastroenteritis.” (R. 378)

On September 10, 1998, McGee complained to her doctor of headaches. (R. 416) She was diagnosed as suffering from acute sinusitis. (*Id.*) She returned to her doctor with the same complaint the next day. (*Id.*) On September 17, 1998, she complained to her doctor of left arm irritation. (R. 413) She was diagnosed as suffering from dermatitis at her IV site. (*Id.*) She went to the hospital on the following day for physical therapy to treat the arm pain. (R. 379-82) On September 21, 1998, McGee was seen by her doctors for diarrhea. (R. 414) On September 24, 1998, she was seen for a headache. (R. 413) On October 3 and 28, 1998, she again was seen for bowel problems. (R. 414, 383-85) Her claimed disability onset date is November 1, 1998.

On November 3, 1998, McGee was hospitalized for diarrhea and dehydration. (R. 389) She was discharged the following day. (*Id.*) On November 6, 1998, she was seen in the emergency room for migraine headaches. (R. 390-91) On November 11, she was hospitalized for dehydration, severe hypertension, colitis, diarrhea, migraine

headaches, diabetes, and depression. (R. 393) Dr. Berdecia noted that McGee's husband had died recently, and she was going through a grieving process. (*Id.*) The doctor prescribed oral Prelone, Naprosyn liquid, Lotrel, Propulsid, Prozac, and Prevacid. McGee also was told to take Midrin as needed for headaches. (*Id.*) She was discharged on November 15, 1998. (*Id.*)

On November 18, 1998, McGee was seen by her doctor for high output from her ostomy. (R. 407, 411) She also was having problems with her blood sugar. (R. 407) On December 2, 1998, she saw her doctor because of colitis, poor control of her diabetes, headaches, and sleeping problems. (R. 406) On December 4, 1998, she called her doctor about sinus headache pain. (*Id.*) She called again on December 10, 1998, complaining of a severe headache and a shaky feeling, and her medication was adjusted. (R. 404-05) She saw her doctor about her headaches again on January 6, 1999. (R. 597) A CT scan on January 8, 1999, confirmed that she was suffering from acute sinusitis. (R. 596)

On January 11, 1999, McGee again was hospitalized for dehydration from high ostomy output. (R. 423) She was treated with aggressive IV fluid hydration and antibiotics, and was discharged the following day. (*Id.*) She reported headaches again on January 13 and 15, 1999. (R. 595-96)

On January 15, 1999, Dr. Berdecia wrote to the Iowa Department of Transportation, stating McGee had a permanent handicap because of her diabetes, severe hypertension, and colitis. (R. 424)

From January 17 to 19, 1999, McGee was hospitalized for dehydration. (R. 425-33, 631) She was rehydrated, and her insulin-dependent diabetes was treated. (R. 426) Dr. Fagre stated McGee was "well known to this service with a long standing history of recurrent gastroenteritis and a dumping syndrome from an ileostomy due to ulcerative colitis." (*Id.*) On January 22, 1999, she was again admitted to the hospital for high

ostomy output and headaches. (R. 434-39, 627) On January 25, 1999, after reviewing the results of laboratory tests, Dr. Berdecia diagnosed McGee as suffering from hypotension, hypokalemia, diabetes, and colitis. (R. 446) She was transferred to the Mayo Clinic. (R. 450)

From January 25 to 29, 1999, McGee was examined at the Mayo Clinic. (R. 447-57) Several tests were performed to identify the cause of her increased ileostomy output, but all were negative except for a suggestion of bacterial overgrowth. She was put on an antibiotic cycle to treat the bacteria. (R. 451) The Mayo doctors determined that McGee's diabetes was not well controlled because she had not been following her diabetic diet. McGee was given instructions about her diet, and her medication was adjusted. (*Id.*) She was discharged with no functional restrictions. (R. 452) Lisa A. Boardman, M.D. wrote the following in McGee's discharge report:

My impressions and recommendations are as follows:

- Increased ileostomy site output

Mrs. McGee had had an ileostomy placed approximately 20 years ago, and in March 1997 she underwent an ileostomy revision. She has since had increased output from her stoma with multiple admissions for diarrhea which has resulted in hypomagnesemia, hypokalemia, and dehydration. She came to Saint Marys Hospital on January 26, 1999, and had an esophagogastroduodenoscopy which revealed that she had no evidence of mucosal disease within the first section of the small intestine; however, an aspirate grew >100,000 colony-forming units consistent with bacterial overgrowth. As well, she underwent an ileostomy which showed normal small bowel mucosa. She had a CT scan of the abdomen and pelvis on January 26, 1999, which was normal. Her small bowel follow-through on January 27, 1999, showed normal bowel without evidence of mechanical obstruction. It was believed that the portion of the increased stool output that was associated with dehydration was related to her diet. For this reason, she was

instructed on the use of Ceralyte as well as magnesium and potassium replacements orally. She was also instructed to follow her diabetic diet more carefully. She will use Ceralyte sipping solution in order to try to maintain her electrolyte balance. It was also recommended that if she notices that her stool output increased significantly that she have laboratory tests done to determine if she is developing electrolyte imbalances. We also recommended that she follow her stool output by measuring it on a daily basis. A fluid restriction of 1.5 liters also led to a great decrease in her stool output to approximately 1.5 liters a day.

- Bacterial overgrowth

It was felt that the bacterial overgrowth is a component of her increased stool frequency, and she was begun on Ciprofloxacin 500 mg twice a day for the first five days of the month alternating with another antibiotic for the first five days of the other month. She may need to be on this chronically, but after three months of antibiotic therapy, she will have a trial without antibiotics to determine the need for long-term antibiotic treatment.

- Diabetes mellitus

She was evaluated by the Diabetes Service who simplified her regimen. They also recommended discontinuation of Glucophage because this may aggravate diarrhea. She had a glycosylated hemoglobin of 6.6 on admission.

- Ulcerative colitis

She is not having any apparent difficulty in terms of pouchitis or extraintestinal manifestations of ulcerative colitis since her colectomy.

- Electrolyte imbalances

This was, again, felt to be related to the increased output through her stoma; and she is to follow the measures as outlined above.

(R. 447-48)

On January 30, 1999, the day after her discharge from the Mayo Clinic, after staying up late the night before at a concert, McGee was admitted to the Waverly Municipal Hospital with dehydration, hypertension, low borderline potassium, and low magnesium. (R. 458-68, 619-20, 594) She was given IV fluids, magnesium, and potassium. On February 9, 1999, she was admitted to the hospital for vomiting and abdominal pain. (R. 472-73) She was rehydrated with IV fluids. (R. 472) Tests suggested possible kidney problems. (*Id.*) She was referred for counseling and possibly a psychiatric evaluation for depression. (*Id.*)

On February 12, 1999, she was seen at the Waverly Municipal Hospital emergency room, complaining of abdominal pain. (R. 478) She was given IV fluids, Demerol, and Vistaril. (*Id.*) At a follow-up visit with Dr. Berdecia on February 17, 1999, she reported she was feeling better, but was still having problems with output. (R. 593) She returned to her doctor on February 24, 1999, complaining of swollen legs. (R. 592)

On March 2, 1999, a licensed mental health counselor reported she had visited with McGee twice, and McGee appeared to be struggling with grief over the death of her husband. (R. 485) On March 3, 1999, McGee saw her doctor about her diabetes, hypertension, and sleeping difficulties. (R. 592) On March 10, 1999, she saw her doctor for severe abdominal pain and sinusitis. (R. 591) A pelvic CT performed on March 12, 1999, was negative. (R. 487) She returned to her doctor on March 19, 1999, with continued complaints of pelvic pain, and unusual headaches. (R. 590) On March 22, 1999, she saw her doctor again about constant, dull, upper-quadrant pain, with occasional sharp pain and a persistent headache. (R. 591) On March 23, 1999, she complained to her doctor about continued pelvic pain, difficulty breathing, and knee and joint pain. (R. 590)

On March 29, 1999, John A. May, M.D. completed a Physical Residual Functional Capacity Assessment for DDS. (R. 494-501) He determined McGee could lift fifty pounds occasionally and twenty-five pounds frequently; stand and/or walk for about six hours in an eight-hour workday; and sit, with normal breaks, about six hours in an eight-hour workday. She had no limitations on her ability to push or pull. She also had no postural, manipulative, visual, communicative, or environmental limitations. Dr. May concluded McGee's allegations were "consistent and credible." (R. 502) He stated, "She is currently taking care of children in her home. No limitations have been placed by her treating sources. The RFC is a reflection of the body of evidence contained within the file." (*Id.*)

On April 7, 1999, McGee saw her doctor about crying spells, apparently resulting from continuing grief over the loss of her husband. (R. 589) She was diagnosed as suffering from an adjustment disorder with depressed mood, and her medication was adjusted. (*Id.*) On April 27, 1999, she saw her doctor about elevated blood sugar, dysmenorrhea, and headaches. (R. 588) Her medication again was adjusted. (*Id.*) She returned to the doctor the same day for burning and shooting pain in her head. She was given Nubain and Vistaril. (*Id.*) On the following day, April 28, 1999, she called to report that she had awakened with a "terrible" headache. (*Id.*) On April 29, 1999, she called to report her headache was severe, and her face felt like it was burning. (R. 587) On April 30, 1999, she called her doctor about her headaches, and then went to the emergency room. She was sent home with instructions to rest. (R. 506) An MRI of her head and an EEG, both performed on May 5, 1999, were normal. (R. 511-13) On May 7, 1999, McGee saw Brian Sires, M.D., a neurologist, about the headaches. (R. 514-15) Dr. Sires recommended McGee's hormone replacement regimen be changed or discontinued. (R. 514) He commented, "I understand [Dr. Berdecia has] already initiated

this.” (R. 514) McGee’s headaches continued throughout May and June 1999, with frequent visits to her doctor and to the hospital.

On July 27, 1999, Gary J. Cromer, M.D. completed a Physical Residual Functional Capacity Assessment for DDS. (R. 523-30) He determined McGee could lift twenty pounds occasionally and ten pounds frequently; stand and/or walk for about six hours in an eight-hour workday; and sit, with normal breaks, about six hours in an eight-hour workday. She had occasional postural limitations, but no limitations on her ability to push or pull, and no manipulative, visual, communicative, or environmental limitations. Dr. Cromer concluded as follows:

Subjective reports reveal numerous inconsistencies. Claimant has a history of dietary noncompliance that was determined to be the primary factor in causing her GI symptoms. Despite her ongoing GI allegations, she hasn’t been hospitalized for same since 2/99 while gaining 25#. She has exhibited drug-seeking behavior and overuse of narcotics, and has been non-compliant in following up with her neurologist regarding her headaches. These inconsistencies have eroded claimant’s credibility.

(R. 531)

On August 18, 1999, Glenn F. Haban, Ph.D. completed a psychological evaluation of McGee for DDS. (R. 533-36) His diagnosis was as follows: “Ms. McGee is currently functioning within the normal range for orientation and cognitive capacity. The mental status examination suggests bereavement. No other Axis One Disorders were identified.”

(R. 535)

On August 31, 1999, McGee was seen at the Waverly Municipal Hospital for bleeding spots on her stoma. (R. 642) McGee reported that the spots had been present for several weeks. (*Id.*) She also reported that her ostomy appliance was not fitting well, and was leaking on occasion. (*Id.*) Dr. Morey noted McGee’s ostomy output was better,

but also observed there was granulation tissue on the ostomy with bleeding. (*Id.*) Dr. Morey had McGee return to the hospital on September 2, 1999, so the granulation tissue on the stoma could be excised and sutured. McGee was told to follow up with an ostomy nurse to get a better fitting ostomy appliance. (*Id.*)

On September 24, 1999, Dr. Berdecia wrote the following to McGee's attorney:

This letter is concerning Ms. Kara McGee. . . . This lady has had extensive medical problems that include the following: She has problems with Severe Hypertension, Insulin Dependent Diabetes, has been diagnosed with Colitis at an early age of 16. This lady indeed was one of the very first patients that underwent a colostomy procedure in Iowa City about twenty plus years ago. By their own recommendation they never expected her to last this long with a colostomy because of her medical problems. She has bouts where she has multiple problems that include chronic and persistent diarrhea that over the last two years have required multiple hospitalizations with the problem of developing severe problems with electrolyte imbalance. She has not only been seen in Iowa City [but] also has been seen in Mayo Clinic as you could probably surmise from copies of her medical records. She is on multiple medications for treatment of the above mentioned conditions as well as the medications she requires because of recurrent migraine headache. Obviously in terms of being able to obtain employment with all these medical conditions it would be extremely hard if not impossible at best since this will be a kind of person that obviously will spend most time out at any work place.

(R. 679)

On September 30 and October 1, 1999, tests were performed on McGee's gallbladder and liver. (R. 571, 573) She was found to have three gallstones, and probable diffuse fatty infiltration of the liver. On October 8, 1999, after another episode of abdominal pain, her gallbladder was removed. (R. 556-58)

On October 4, 1999, Beverly Westra, Ph.D. completed a Psychiatric Review Technique form and a Mental Residual Functional Capacity Assessment form. (R. 539-47, 551-54) Dr. Westra concluded McGee had an adjustment disorder with depressed mood (R. 542), but she otherwise had no psychiatric problems. Dr. Westra found McGee would be limited slightly in the activities of daily living and maintaining social functioning, and often would be deficient in concentration, persistence, or pace. (R. 546) She found McGee's mental functioning was not significantly limited, except for moderate limitations in the ability to understand, remember, and carry out detailed instructions, and the ability to maintain attention and concentration for extended periods. (R. 551) Dr. Westra concluded McGee's "[a]ttention and concentration would be adequate for most simple tasks, but moderately impaired for highly complex or detailed information and for sustained attention for prolonged periods of time." (R. 555)

On November 1, 1999, Dr. Morey surgically placed an "L internal jugular Titan port" in one of McGee's veins because of the "[n]eed for long term IV access." (R. 559) On November 6, 1999, McGee went to the hospital complaining of headaches, and she saw her doctor on November 10, 1999, still complaining of headaches. (R. 577, 666) On November 12, 1999, she went to the hospital for dehydration, and was given IV fluids through her port. (R. 638) On November 15, 1999, she saw her doctor for headaches and dizziness. (R. 576)

On November 18, 1999, McGee was seen by Suresh Reddy, M.D., a gastroenterologist, for abnormal liver enzymes. (R. 644-45) Dr. Reddy's diagnosis was as follows:

Elevated liver enzymes with liver biopsy showing fatty liver.  
Intraoperative cholangiogram apparently was abnormal,  
showing some strictures in the bile ducts, suggestive of P.S.C.

(R. 645)

On November 21, 1999, McGee was seen at the Waverly Municipal Hospital for increased ostomy output during the previous two days, and for achiness, sweating, headaches, and nausea. (R. 646) She was told to rehydrate orally. (R. 647) She saw Dr. Fagre on November 27, 1999, for vomiting, diarrhea, body pain, fever, chills, sweats, and difficulty urinating. (R. 575) She was sent to the hospital, where she was rehydrated, and she was discharged on November 29, 1999. (R. 651)

On December 8, 1999, Dr. Reddy evaluated McGee for profuse diarrhea and increased ostomy output since her gallbladder surgery. (R. 653) He referred her to Dr. Reedy for an ERCP.<sup>2</sup> After the procedure, Dr. Reddy diagnosed multiple strictures in the intrahepatic duct suggestive of sclerosing cholangitis. (R. 655) Dr. Reddy commented that there are no specific medications available to treat the condition. (*Id.*) In a follow-up report, Lawrence Liebscher, M.D. presented several possibilities that could explain this problem, but reached no conclusions. (R. 654) In a pathology report from the Mayo Clinic dated December 14, 1999, the pathologist noted “histologic findings are consistent with small duct primary sclerosing cholangitis, stage 2-3.” (R. 667)

In an opinion letter dated December 14, 1999, Roger L. Skierka, M.D., one of McGee’s treating physicians, wrote the following:

Kara is a young lady who has a long history of a diagnosis of ulcerative colitis. As a young child she did have surgical removal of a large section of her colon. Since that time she has had a colostomy bag to help with her bowel movements. Complications of that include arthritis from which she is currently suffering. She also has a history of liver changes. She recently underwent a cholecystectomy to remove her gallbladder and subsequently had elevated liver function tests

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<sup>2</sup>ERCP is shorthand for Endoscopic Retrograde Cholangiopancreatography, which is a diagnostic procedure used primarily to examine the bile ducts, gallbladder, duodenum, and pancreatic duct.

at that time. She recently had a liver biopsy which the results are pending but it did show some chronic signs of change secondary to what was presumed to be the ulcerative colitis.

The patient is also suffering from diabetes mellitus for which she does require insulin. Although her blood sugars have currently been under good control she has had a history of poor control over this problem.

She also suffers from depression and anxiety attacks as well. She is on an extensive amount of medicines for the GI upset secondary to the ulcerative colitis. We have a very difficult time managing her medical problems but with the assistance of specialists in Waterloo and with verbal assistance from Iowa City and Mayo[,] we have been able to maintain good relationships with her and keep her out of the hospital for an extended period of time.

We are requesting at this time any assistance you can give us in regards to this [patient's] medical problems and her inability to function in an employment status. Because of her diabetic problem, arthritis and other problems associated with her ulcerative colitis[,] we do not feel that she is capable of working outside of the home.

Although she is attempting to do everything she can to maintain her own ability to function on her own, she is having a very difficult time. Any assistance that can be given at this time would be deeply appreciated.

(R. 657-58)

On April 5, 2000, McGee went to the hospital because of dehydration after twenty-four hours of vomiting. (R. (671-72) On April 10, 2000, Dr. Morey performed a “[r]ectal exam under anesthesia and curettage of abnormal mucosa versus granulation tissue.” (R. 675)

On April 19, 2000, Dr. Skierka wrote another letter, and supplemented his earlier opinions as follows:

She did have her gallbladder removed several months ago secondary to an acute inflammatory reaction of that organ. It was in hopes that this would help resolve some of the liver problems as the two are closely related. Unfortunately after discussing this in detail with him, the Gastroenterologist Dr. Reddy, stated that he felt the patient was going to eventually develop more liver complications secondary to the ulcerative colitis. In light of this we do have to monitor her liver function tests on a 6 month basis and maintain close regulation of that to help avoid any problems. She also subsequently has type I or insulin dependent diabetes. Her numbers have been under decent control recently. She takes a significant amount of insulin to help control this diabetic problem. She is suffering from depression at this time. Because of her medical problems she is on a lot [sic] of different medicines at this time. She has frequent physician visits both to primary care physicians such as myself and to specialist[s] such as the surgeon. The surgeon recently did a procedure on the patient to remove a cyst in her abdominal region.

It was an infectious agent in a fistula forming body. This is just another complication that this [patient] has to endure due to her chronic ulcerative colitis and the manifestations of that disease. She is now starting to develop the arthritis that is also associated with the ulcerative colitis. She also has a subsequent risk of developing cancer associated with the ulcerative colitis.

\* \* \*

In light of her many medical problems and the need to frequently visit physicians for these problems it is felt that any assistance that can be provided for this patient would be greatly appreciated by both the medical professionals and also by the patient. . . . She is . . . unable [to do] most types of manual labor due to the arthritis and the chronic problems that she suffers from.

(R. 677-78)

Dr. Skierka wrote a third letter on November 1, 2000, stating, in part:

It is my medical opinion that this woman does have significant disability due to her chronic medical problems. Taken individually, I am sure most people could handle hypertension without any problem or diabetes without any problem or depression. Unfortunately this woman has a combination of many medical problems that have caused a significant debilitation.

(R. 688)

On August 23, 2000, after the initial administrative hearing in this case, Paul From, M.D., an internist, reviewed the medical records in the case at the ALJ's request and answered certain interrogatories. (R. 681-86) In his answers, Dr. From stated that McGee has severe impairments, but no specific impairment meets the Listing criteria. He stated, "There is no documentation that the impairment is disabling other than for statement[s] from 2 attending physicians. These opinions differ somewhat from listed objective criteria in previous evaluations." (R. 682) He further stated when "compliance [with the prescribed treatment] was good, the problems with ileostomy output and electrolyte imbalance seemed to be under fairly good control. However, the development of depression and then the cholangitis later occurred. The attending physicians do not comment upon non-compliance, but this is readily apparent in other documents in [the Record]." (R. 683)

On November 16, 2000, at the request of McGee's attorney, Dr. From testified before the ALJ. (R. 119-32) Dr. From testified he is board certified in internal medicine. (R. 120-21) He was retained by the Social Security Administration to review McGee's medical records and to answer interrogatories, as discussed above. (R. 121-22) According to Dr. From, McGee's impairments, even when viewed in combination, do not meet the requirements of the Listings. (R. 122) Dr. From testified that from his review

of the medical records, it appeared the high output from McGee's ileostomy was caused by dietary noncompliance and bacterial overgrowth of the small bowel. (R. 125) To support his testimony that McGee had not complied with dietary restrictions, Dr. From could point only to his recollection that he had read about this problem "more than one time" when he had reviewed McGee's medical records. (R. 127)<sup>3</sup>

McGee testified in response to Dr. From's testimony that she had followed the dietary restrictions given to her by her doctors, and she had never been told by a doctor that she had been noncompliant. (R. 132-33)

### **3. *Vocational Expert's Testimony***

The ALJ asked the VE the following hypothetical question:

My first assumption is that we have an individual who is 38 years old. She was 36 years old as of the alleged onset date of disability. She's a female. She has a high school general equivalency diploma and past relevant work, and we're gonna limit that to the childcare worker. And she has the following impairments: She is status post ileostomy, secondary to the total colectomy with dumping syndrome and colitis; Insulin dependent diabetes mellitus, hypertension, gastro-esophageal reflux disease, obesity, status post gallbladder surgery, reactive airway disease, degenerative changes of the lumbar spine, history of migraine headaches and an adjustment disorder with depressed mood. As a result of a combination of those impairments, she has the residual functional capacity as follows: She cannot lift more than 20 pounds, routinely lift

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<sup>3</sup>The only reference the court can locate in the Record that mentions dietary non-compliance is in a report from the Mayo Clinic, where Dr. Boardman stated, "It was believed that the portion of the increased stool output that was associated with dehydration was related to her diet," and McGee was "instructed to follow her diabetic diet more carefully." (R. 447) Besides this one instance, the court finds no other support for the statement by medical consultant Dr. Cromer that McGee "has a history of dietary noncompliance that was determined to be the primary factor in causing her GI symptoms." (R. 531)

10 pounds, with no standing [of] more than 60 minutes at a time. Walking of two to three blocks at a time. No repetitive bending, stooping, or squatting. No continuous kneeling, crawling or climbing. This individual should not be exposed to excessive heat, humidity or cold or more than moderate levels of dust or fumes. She is not able to do very complex or technical work, but is able to do more than simple, routine, repetitive work, which does not require constant attention to detail. She should not work at more than a regular pace and that's using three speeds of pace being fast, regular and slow. And she should not work at more than a moderate level of stress. Would this individual be able to perform any jobs she previously worked at, either as she performed it, or as it is generally performed within the national economy and if so, would you please specify which job?

(R. 110-11) The VE responded this person would be able to perform McGee's past work as a childcare provider. (R. 111)

The ALJ next asked the VE the following hypothetical question:

My next hypothetical would be an individual with the same age, sex, education, past relevant work and impairments as previously specified. And this would be an individual who would have the residual functional capacity as follows: This individual could not lift more than 15 to 20 pounds, routinely lift 10 pounds, with no standing of more than 20 minutes at a time, no sitting of more than two hours at a time and no walking of more than three to four blocks at a time. With no repetitive bending, stooping, squatting, kneeling, crawling or climbing. No repetitive gross or fine manipulation for periods of time exceeding a half hour at a time, with no repetitive work with the arms overhead. This individual is not able to do very complex or technical work, but is able to do more than simple, routine repetitive work which does not involve a stress level of more than a mild to moderate degree of stress. Would this individual be able to perform any jobs she previously

worked at either as she performed it, or as it generally performed within the national economy?

(R. 111-12) The VE responded this individual also would be able to perform work as a childcare provider. (R. 112) The VE further testified this individual could perform a number of jobs within the economy, for example, as a courier messenger, a surveillance monitor, or a parking lot cashier. (R. 113) The VE clarified that if the individual required frequent, unscheduled breaks from regular work activity, then normal employment would be eliminated, although scheduled breaks would not eliminate these jobs. (R. 113-14)

On cross-examination by McGee's attorney, the VE testified the individual in the ALJ's hypothetical would not be employable if the individual had the following additional problems:

[T]his person also was suffering from depression and was on several types of medications; the same medications . . . that have previously been introduced into evidence. And you also assume that this person would miss at least one day and maybe one and a half days of her week, seeking medical attention because of [her] condition, and also [, it is] necessary for this person to take unscheduled breaks up to once an hour to perform a personal function such as changing her bag[.]

(R. 114) The VE testified that the last two parameters would preclude employment. (*Id.*)

#### **4. *The ALJ's conclusions***

In his decision, the ALJ reviewed McGee's medical records in detail, and then commented that he gave "little weight" to Dr. Skierka's opinion on the severity of McGee's limitations. (R. 35) The ALJ stated the following:

[McGee] has no ongoing treatment for liver disease and was noted to be asymptomatic and the elevation of her liver enzymes was not significant. Her complaints of migraine headaches had stabilized by November 1999. Objective

medical evidence showed only mild to moderate degenerative changes in her spine, and the claimant reported significant relief following facet and epidural injections. There is no objective evidence of a recurrence of the claimant's ulcerative colitis, and she was able to control her diarrhea without emergency room or physician treatment from February 1999 until November 1999. The medical records show she increased her weight from February 1999 until November 1999 by 27 pounds, indicative of little difficulty assimilating food.

(R. 35-36)

In commenting on McGee's testimony, the ALJ found her subjective complaints "to be not fully credible, and her symptoms to be not as limiting as alleged." (R. 37) As support for this conclusion, he stated the following: "The undersigned finds nothing in the evidence of record to indicate that the claimant returned to Dr. Sires after his recommendation that she discontinue her hormone therapy. Her list of current medications does not show any hormone replacement medications, and her headaches stabilized after she was examined by Dr. Sires."<sup>4</sup> (R. 38)

The ALJ found as follows:

Based on the claimant's testimony, the undersigned finds that she retains the following residual functional capacity: She can occasionally lift and carry 20 pounds and can frequently lift and carry 10 pounds. She can stand for 60 minutes and walk 2 to 3 blocks. She can do no continuous kneeling, crawling, and climbing and can not repetitively bend, stoop, and squat. She should avoid exposure to excessive heat and cold temperatures and should avoid more than moderate exposure to dust and fumes. She is not able to do very complex technical work but is able to perform more than simple, routine, repetitive work. She can work at no more than a

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<sup>4</sup>This simply is not true. After McGee saw Dr. Sires on May 7, 1999, she complained of headaches on May 9, 13, and 14; June 18 and 28; and November 6, 10, 15, and 21, 1999.

regular pace, at more than a moderate stress level, and in jobs not requiring constant attention to detail.

(R. 38-39) The ALJ found McGee had the physical and mental capacity to work as a child care provider, and she therefore was not prevented from performing her past relevant work. (R. 40) Based on these finding, the ALJ concluded McGee was not disabled within the meaning of the Social Security Act at any time through the date of his opinion, and therefore was not entitled to DI benefits. (R. 30, 39)

### ***III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD***

#### ***A. Disability Determinations and the Burden of Proof***

Section 423(d) of the Social Security Act defines a disability as the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.” 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is “not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country.” 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *see Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe

impairment; *i.e.*, “one that significantly limits the claimant’s physical or mental ability to perform basic work activities.” *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant’s impairments and vocational factors such as age, education and work experience. *Id.*; *accord Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) (“[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.”) (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)).

Step five requires that the Commissioner bear the burden on two particular matters:

In our circuit it is well settled law that once a claimant demonstrates that he or she is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O’Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

*Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added); *accord Weiler v. Apfel*, 179 F.3d 1107, 1110 (8th Cir. 1999) (analyzing the fifth-step determination in terms

of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

### ***B. The Substantial Evidence Standard***

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Weiler, supra*, 179 F.3d at 1109 (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley, supra*, 133 F.3d at 587 (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier, id.*; *Weiler, id.*; accord *Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the

Commissioner's decision as well as evidence that supports it." *Krogmeier*, 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell, id.*; *Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does "not reweigh the evidence or review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); see *Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); accord *Krogmeier*, 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997); accord *Pearsall*, 274 F.3d at 1217; *Gowell, supra*.

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.*, 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen*, 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.*, 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.*, 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan*, 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler*:

The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:

- 1) the claimant's daily activities;
- 2) the duration, frequency and intensity of the pain;
- 3) precipitating and aggravating factors;
- 4) dosage, effectiveness and side effects of medication;
- 5) functional restrictions.

*Polaski*, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

## IV. ANALYSIS

### A. *Opinions of Treating Physicians*

McGee argues the ALJ erred in improperly discrediting or ignoring the opinions of McGee's treating physicians. The court agrees.

"A treating physician's opinion should not ordinarily be disregarded and is entitled to substantial weight. *Ghant v. Bowen*, 930 F.2d 633, 639 (8th Cir. 1991). By contrast, '[t]he opinion of a consulting physician who examines a claimant once or not at all does not generally constitute substantial evidence.' *Kelley v. Callahan*, 133 F.3d 583, 589 (8th Cir. 1998)." *Jenkins v. Apfel*, 196 F.3d 922, 925 (8th Cir. 1999).

In *Prosch v. Apfel*, 201 F.3d 1010 (8th Cir. 2000), the Eighth Circuit Court of Appeals discussed the weight to be given to the opinions of treating physicians:

The opinion of a treating physician is accorded special deference under the social security regulations. The regulations provide that a treating physician's opinion regarding an applicant's impairment will be granted "controlling weight," provided the opinion is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] record." 20 C.F.R. § 404.1527(d)(2). Consistent with the regulations, we have stated that a treating physician's opinion is "normally entitled to great weight," *Rankin v. Apfel*, 195 F.3d 427, 430 (8th Cir. 1999), but we have also cautioned that such an opinion "do[es] not automatically control, since the record must be evaluated as a whole." *Bentley v. Shalala*, 52 F.3d 784, 785-86 (8th Cir. 1995). Accordingly, we have upheld an ALJ's decision to discount or even disregard the opinion of a treating physician where other medical assessments "are supported by better or more thorough medical evidence," *Rogers v. Chater*, 118 F.3d 600, 602 (8th Cir. 1997), or where a treating physician renders inconsistent opinions that undermine the credibility of such opinions, *see Cruze v. Chater*, 85 F.3d 1320, 1324-25 (8th Cir. 1996).

Whether the ALJ grants a treating physician's opinion substantial or little weight, the regulations provide that the ALJ must "always give good reasons" for the particular weight given to a treating physician's evaluation. 20 C.F.R. § 404.1527(d)(2); *see also* SSR 96-2p.

*Prosch*, 201 F.3d at 1012-13. *See Wiekamp v. Apfel*, 116 F. Supp. 2d 1056, 1063-64 (N.D. Iowa 2000). *See also Rankin v. Apfel*, 195 F.3d 427, 429 (8th Cir. 1999) (where physician's conclusion is based heavily on claimant's subjective complaints and is at odds with the weight of objective evidence, ALJ need not give physician's opinion the same degree of deference) (citing *Haggard v. Apfel*, 175 F.3d 591, 595 (8th Cir. 1999)).

Dr. Berdecia and Dr. Skierka, both treating physicians, are of the opinion that McGee has significant functional limitations that, if accepted as true by the ALJ, would have precluded all employment. The ALJ simply ignored the opinions of Dr. Berdecia without comment, and decided to give "little weight" to the opinions of Dr. Skierka with no real justification. Instead, the ALJ relied on evidence from Dr. From, a non-treating, non-examining physician.

Dr. From's conclusions were based primarily on his belief that McGee's continuing problems were caused by dietary noncompliance. In the voluminous Record, there is only one reference to dietary noncompliance by a treating physician. Dr. Boardman simply stated it was *believed* that a *portion* of McGee's increased stool output was *related to* her diet, and McGee was "instructed to follow her diabetic diet more carefully." (R. 447) This is a thin thread upon which to ignore the substantial evidence in the Record supporting the opinions of McGee's treating physicians.

In light of contrary evidence from McGee's treating physicians, the opinions of Dr. From, a consulting physician, cannot constitute substantial evidence to support the ALJ's denial of benefits. *See Jenkins*, 196 F.3d at 925 (citing *Kelley*, 133 F.3d at 589).

The opinions of McGee's treating physicians provided substantial evidence that she is disabled under the provisions of the Social Security Act.

***B. The Polaski Standards and the ALJ's Hypothetical Questions***

Although the court does not need to reach these issues, it is apparent on the Record that the ALJ improperly discredited McGee's testimony concerning her functional limitations. Without even giving lip-service to the *Polaski* standards, the ALJ concluded, with little support, that McGee's testimony was "not fully credible." This is just the type of reasoning the court in *Polaski* was attempting to prevent. An ALJ may not discredit a claimant's subjective allegations of disabling limitations without justification, even where there is a lack of objective medical evidence, unless such allegations are inconsistent with the Record as a whole. Here, far from being inconsistent with the Record, substantial objective evidence *supports* McGee's testimony.

McGee testified that she must change her ostomy bag twenty times each day, and it takes from five to ten minutes to complete the procedure. She also testified she spends an average of a day-and-a-half each week in doctors' offices and hospitals. She testified that she suffers from disabling migraine headaches two to three times a week.<sup>5</sup> All of this testimony is supported, or at least is uncontradicted, in the Record. The VE testified that an individual with these restrictions would be unemployable. Therefore, this evidence, if accepted, would have established that McGee is disabled under the Social Security Act. The ALJ's rejection of this evidence was virtually without justification.

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<sup>5</sup> Although McGee can control these headaches with medication, she testified that when she feels a migraine headache coming on, she must take the medication and then lie down for twenty minutes to an hour before the headache goes away.

It is difficult to determine how the ALJ could have looked at this Record, seen what McGee has to go through to live her life, read the opinions of her treating physicians, and then decide she is not disabled. It is patently obvious that no one with McGee's medical problems and the resulting functional limitations would be employable anywhere in the national economy.

Similarly, the only appropriate hypothetical question asked of the VE was the question asked by McGee's attorney. The VE's response to the hypothetical question was that the individual described in the question would be precluded from all employment.

For these reasons, the court finds McGee is disabled and is entitled to benefits from her alleged disability onset date of November 1, 1998.

## ***V. CONCLUSION***

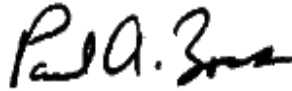
Having found McGee is entitled to benefits, the court may affirm, modify, or reverse the Commissioner's decision with or without remand to the Commissioner for a rehearing. 42 U.S.C. § 405(g). In this case, where the record itself "convincingly establishes disability and further hearings would merely delay receipt of benefits, an immediate order granting benefits without remand is appropriate." *Cline*, 939 F.2d at 569 (citing *Jefferey v. Secretary of H.H.S.*, 849 F.2d 1129, 1133 (8th Cir. 1988); *Beeler v. Bowen*, 833 F.2d 124, 127-28 (8th Cir. 1987)); accord *Thomas v. Apfel*, 22 F. Supp. 2d 996, 999 (S.D. Iowa 1998) (where claimant is unable to do any work in the national economy, remand to take additional evidence would only delay receipt of benefits to which claimant is entitled, warranting reversal with award of benefits).

Accordingly, for the reasons discussed above, the Commissioner's decision is **reversed**, and this case is **remanded** to the Commissioner for a calculation and award of benefits.

*Plaintiff's counsel is directed to submit a timely application for attorney fees in accordance with Local Rule 54.2(b).*

**IT IS SO ORDERED.**

**DATED** this 8th day of December, 2003.

A handwritten signature in black ink, appearing to read "Paul A. Zoss", is written above a horizontal line.

PAUL A. ZOSS  
MAGISTRATE JUDGE  
UNITED STATES DISTRICT COURT

**MEDICAL RECORDS SUMMARY**  
**McGee vs. Barnhart, Case No. C02-3042-PAZ**

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
12/20/96 R. 633-34	Waverly Municipal Hospital Physical Therapy Department Michael R. Kaus, P.T.	Sprained right ankle	Pt referred by Dr. Pattee. Pt has aching and pain going up side of rt. calf. <u>Assessment</u> : Ankle sprain. Work on strengthening ankle and nerve perception in ankle joint.
03/22/97 thru 03/24/97 R. 223-39	Waverly Municipal Hospital Lee O. Fagre, M.D.	Dehydration secondary to gastroenteritis; diabetes	Pt is a 35-yr-old female who had a total colectomy for ulcerative colitis. Pt lost large volumes of fluid through her ileostomy and vomiting. Brought dehydration and blood sugar under control; switched pt to oral meds after 1 day. X-ray of supine and upright abdomen showed little bowel gas; suggestion of a couple of mildly dilated loops of small bowel that could be a mild ileus. Chest X-ray normal. Final Diagnosis: Gastroenteritis, poorly controlled with dehydration; poorly controlled diabetes mellitus; Permanent ileostomy secondary to total colectomy for ulcerative colitis. Rx for Rezulin, Bentyl and some insulin; continue Glyburide.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
03/31/97 R. 241	Waverly Municipal Hospital Lee O. Fagre, M.D.	Diabetes	Primary diagnosis: Insulin dependent diabetes mellitus. Current meds: Glyburide, Rezulin, Insulin, blood pressure medication. Pt referred for "In Control" Diabetes Self Management Education.
04/24/97 thru 04/25/97 R. 242-48	Waverly Municipal Hospital Lee O. Fagre, M.D.	Diabetes; gastro- enteritis w/dumping syndrom and dehydration	Pt has ileostomy for significant large bowel problems. Pt "ends up draining out through her ileostomy every once in a while and gets what appears to be a dumping syndrome and dehydrates." Pt admitted for IV fluids to rehydrate. Pt given Kaopectate, Lomotil, Codiclear DH cough syrup; continue sliding scale Insulin.
07/17/97 thru 07/18/97 R. 249-58	Waverly Municipal Hospital Michael Berstler, M.D.	Vomiting w/dry heaves; frequent loose stools	Pt has an ileostomy for ulcerative colitis; diabetes mellitus Type II; was on Insulin, now on oral meds. Current meds: Lomotil, Rezulin, Glyburide, Lotensin. <u>Assessment</u> : Probable gastroenteritis with frequent stools and nausea with dehydration about 5-7%. Blood sugar 177 presently. Diet and oral medication controlled. Hypertension. Hyperlipidemia. <u>Plan</u> : Pt admitted for IV hydration and monitoring of sugars.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
07/19/97 thru 07/21/97 R. 259-63	Waverly Municipal Hospital John Brunkhorst, M.D.	Weakness, diarrhea	Pt was placed back on IV fluids. Cultures negative. Pt still having a lot of output from her ileostomy. Pt was rehydrated and discharged on Cipro, Lomotil, and Kaopectate. <u>Diagnosis:</u> Acute gastroenteritis, old ileostomy. Pt will be followed on an out-patient basis.
08/22/97 R. 264-67	Waverly Municipal Hospital Robert Choi, M.D. G. E. Raecker, D.O.	Headache, dizziness	CT of head - Negative.
09/09/97 R. 268-74	Waverly Municipal Hospital Lee O. Fagre, M.D.	Diabetes, dehydration	Pt complains of dizziness. IV started. Dizziness much better. Pt discharged to home with a friend.
09/28/97 R. 275-80	Waverly Municipal Hospital Kelly Schmidt, M.D.	Lower abdominal cramping and urinary frequency for past 2 days	Pt complaints as noted at left; also increased ileostomy output (4 gals yesterday), very watery. Current meds: Rezulin, Glyburide, Lobid, Duract, Amitriptyline. Pt did not know her meds and did not have them with her; may be some confusion with the meds. Pt hydrated in E.R.; symptoms improved and she was discharged. <u>Impression:</u> High ileostomy output, mild dehydration, urinary tract infection. <u>Plan:</u> Pt will return if high ileostomy output continues more than 24 hours. Rx for Bactrim DS.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
12/31/97 R. 281-83	Waverly Municipal Hospital John Brunkhorst, M.D.	Dehydration	Pt admitted for rehydration.
01/01/98 R. 284-88	Waverly Municipal Hospital John Brunkhorst, M.D.	Gastroenteritis	Pt admitted for observation; given IV fluids. Pt has an ileostomy from Crohn's Disease. Every time she gets a little diarrhea, she puts out a lot of fluids and gets dehydrated. <u>Diagnosis</u> : 1. Acute gastroenteritis, secondary to flu. 2. Crohn's Disease ileostomy.
01/22/98 R. 293	Dawn Morey, D.O.	Abdominal pain; opinion letter	Pt complains of abdominal pain; has some little blister-type areas on stoma <sup>6</sup> that bleed when she rubs them. <u>Assessment</u> : Abdominal pain, rule out peptic ulcer disease. Also need to make sure she doesn't actually have Crohn's disease rather than ulcerative colitis. <u>Recommendation</u> : Upper GI panendoscopy with biopsy, w/concurrent biopsy of lesions on stoma.
01/22/98 R. 493	Dawn Morey, D.O.	Abdominal and left upper quadrant pain	Consultation for Dr. Fagre. Pt has had recurrent pain and loose stools with dehydration for three weeks. No notes re what treatment was given.

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<sup>6</sup>"Stoma" is defined as "a mouthlike opening, particularly an incised opening which is kept open for drainage or other purposes." *Dorland's Pocket Medical Dictionary*, 642 (23d ed. 1982).

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
01/23/98 R. 289- 92, 294	Waverly Municipal Hospital Dawn Morey, D.O.	Upper GI pan- endoscopy	Pt admitted for upper GI pan- endoscopy with biopsy, and biopsy and fulguration of lesions on stoma. Post-Op Diagnosis: Gastric ulcer and small papilloma on stoma. Gastroparesis.
01/26/98 R. 493	Dawn Morey, D.O.	Abdominal pain	Pt continues to have abdomi- nal pain and cramping, loose stools, diarrhea, poor appetite. "Schedule scope through ileostomy."
01/27/98 R. 295-97	Waverly Municipal Hospital Lee O. Fagre, M.D.	Lab studies	Screen for elevated lead level; results normal.
01/29/98 R. 298- 300	Waverly Municipal Hospital Dawn Morey, D.O.	Endoscopy	Procedure: Small bowel endoscopy with mucosal biopsies. Postoperative diag- nosis: Diarrhea, plus lymphoid hyperplasia with the small bowel.
02/03/98 R. 308-09	Waverly Municipal Hospital Michael Berstler, M.D.	Diarrhea with dehydration	Pt has history of ulcerative colitis with ileostomy and has had almost irritable ileostomy symptoms of dramatic diarrhea with dehydration. <u>Plan:</u> Rx for Prilosec, Nubain, Propulsid. If meds don't help, evaluate for toxicity reaction to meds and for autonomic dysfunction.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
02/04/98 R. 301-06	Waverly Municipal Hospital Lee O. Fagre, M.D.	Right upper quadrant pain	Flat and upright abdominal X-rays. Impression: Partial small bowel obstruction. Postoperative changes of right abdomen. Follow-up suggested.
02/05/98 R. 307	Waverly Municipal Hospital J. R. Hooyman, M.D.	Right upper quadrant pain	CT scan of abdomen with and without contrast: Impres- sion: Mechanical small bowel obstruction at the level of the ileostomy.
02/10/98 R. 492-93	Dawn Morey, D.O.	Follow-up exam re abdominal pain	Upper GI scope showed gastric ulcer and gastro- paresis. Small bowel endoscopy was done to rule out ulcerative colitis. <u>Assessment:</u> Abdominal pain and partial bowel obstruction. <u>Plan:</u> Obtain CT scan films to review and then proceed with revision of her ostomy.
02/17/98 R. 492	Dawn Morey, D.O.		Scheduled revision of ileostomy for 2/20/98.
02/20/98 R. 310-13	Waverly Municipal Hospital Dawn Morey, D.O.	Revision of ileostomy	Postoperative diagnosis: Partial bowel obstruction secondary to constriction at ileostomy site. Current meds: Rezulin, Lopid, Lo-Trol.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
02/22/98 R. 492	Dawn Morey, D.O.	Pain and itching at ostomy site	Pt changed the ostomy appliance because it was leaking and there was redness and discomfort at the skin site under the wafer. <u>Assessment</u> : Contact dermatitis. <u>Plan</u> : Changed the ostomy appliance. Pt given injection of Solu-Medrol and a Medrol dose pack. Pt to take Dramamine and use ice on the area for the itching.
02/27/98 R. 491-92	Dawn Morey, D.O.	Follow-up re ostomy	Pt had a revision of her ostomy on 2/20/98; developed allergic reaction w/contact dermatitis under her stoma appliance. Leaking has stopped; tenderness is gone; ostomy is working well; belly pain is gone and the ostomy output is doing well. <u>Assessment</u> : Status post revision of ileostomy; contact dermatitis, resolving. <u>Plan</u> : Recheck in a month.
03/23/98 R. 491	Dawn Morey, D.O.	Follow-up re ostomy	Localized dermatitis is resolved; pt can apply her normal appliance without difficulty. <u>Assessment</u> : Status post revision of the ileostomy; gastric ulcer. <u>Plan</u> : Continue Prilosec.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
03/28/98 R. 419	Covenant Clinic	Sinus infection, sore throat, nasal congestion, headache	Erythromycin has not helped pt's symptoms. <u>Assessment</u> : 1. Acute sinusitis on the right. 2. Possible URI. 3. Headache secondary to the sinuses. <u>Plan</u> : Pt given Rocephin shot. Pt had to take liquid Erythromycin because of her colectomy and even that gave her loose bowels. Rx for Midrin.
04/27/98 R. 314-16	Waverly Municipal Hospital Lee O. Fagre, M.D.	Right leg pain; CT and X-ray of lumbar spine	X-ray: AP, lateral, both oblique views of the lumbar spine. Impression: Mild to moderate degenerative changes involving lower L-2 spine. CT of L-S spine without intravenous contrast. Impression: No disc herniations. Disc bulges present, most prominent at L4-5 and L5-S1. Spinal canal narrowing is greatest at L4-5, mild due to combination of mild disc bulge with degenerative change.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
05/08/98 thru 05/10/98 R. 317-26	Waverly Municipal Hospital Lee O. Fagre, M.D.	Large output from ileostomy tube; dehydra- tion; gastro- enteritis	Pt feeling poorly and dehy- drating. Pt was put on IV fluids and IV antibiotics; turned out to be urinary tract infection. Chest X-ray: Normal. Pt put on Kaopectate, Lomotil, Lopid, Lotrel, Rezulin, Ibuprofen, Prevacid. <u>Final Diagnosis</u> : 1. Gastroenteritis with marked output from ileostomy causing dehydration. 2. Leukocytosis. 3. UTI. 4. Non Insulin dependent diabetes mellitus. 5. Hyper- tension. 6. Hyperlipidemia. 7. Gastroesophageal reflux disease.
05/23/98 R. 419	Covenant Clinic	Rash	Pt seen yesterday because of onset of rash. Pt had UTI and was put on Macrochantin. Now she has little spots which got worse overnight. <u>Assessment</u> : Cellulitis on arms, right axilla and abdomen. <u>Plan</u> : Rx for Keflex. Culture the rash.
05/26/98 R. 332-34	Waverly Municipal Hospital Lee O. Fagre, M.D.	Lab studies	Organism: Staph aureus

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
05/27/98 thru 05/29/98 R. 327-31	Waverly Municipal Hospital Lee O. Fagre, M.D.	Cellulitis	Pt admitted with staphylococcal cellulitis that was treated with IV antibiotics. After a few days of IV treatment and soaks, erythema and abscess draining went down. Pt discharged with good cleansing techniques and Rx for Keflex. Pt to keep tight control of her diabetes. <u>Final Diagnosis:</u> 1. Cellulitis with staphylococcal aureus abscesses. 2. Diabetes mellitus, poorly controlled. 3. Hypertriglyceridemia. 4. Hypertension. 5. Degenerative joint disease.
06/19/98 thru 06/22/98 R. 335-39; 340-45	Waverly Municipal Hospital Lee O. Fagre, M.D.	Abdominal pain; leg cramps; dehydration	Pt was brought in for chronic dumping syndrome with secondary dehydration and underlying abdominal pain. High ostomy output. Question whether Pt has Crohn's disease instead of ulcerative colitis which may be causing her current problem. Pt scheduled to go to Iowa City as an outpatient. <u>Final Diagnosis:</u> 1. Dumping syndrome. 2. Diarrhea. 3. Vomiting. 4. Colostomy. 5. Diabetes mellitus. 6. Inflammatory bowel disease.

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
07/05/98 R. 349-54	Waverly Municipal Hospital Francis Coyle, M.D.	Right knee pain, chills, abdominal pain	Pt complains of right knee pain. Pt returns in the afternoon complaining of chills. Diagnosis: Diabetes and post ileostomy. Pt to go to Iowa City tomorrow.
07/06/98 R. 355-56	University of Iowa Hospitals and Clinics Robert W. Summers, M.D. Pamela Fick, M.D.	Consultative examination report	Pt was interviewed and examined at the Center for Digestive Diseases on 07/06/98. Diagnoses: 1. History of ulcerative colitis, status post revision of ileostomy in February of 1998. 2. History of adult onset diabetes mellitus. 3. History of hypertension. 4. Obesity. Pt presents for evaluation of increased ileostomy output associated with abdominal cramps. Pt has required two hospitalizations in May and one in June for IV fluid hydration. She has also received IV fluid as an outpatient every other week for the past month. Pt noted that fluid "squirts" out of her ostomy site. Rezulin and Glyburide were discontinued over 1 1/2 mos. ago, hoping high ostomy output was secondary to diarrhea caused by the meds, but symptoms have continued. Neither Lomotil nor Donnatal has provided much relief. Glucose levels still range

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			<p>between 103 and 176. Current meds: Lotensin, Lopid, Lotrel, sliding Humulin insulin scale, Lomotil, Donnatal. <u>Assessment/Plan</u>: Intermittent crampy abdominal discomfort with high ostomy output. Due to Pt's multiple abdominal surgeries for her Crohn's disease, there is a concern she may have recurrent bowel obstruction. Pt is scheduled for a small bowel enteroscopy.</p>
07/07/98 R. 357-59	University of Iowa Hospitals and Clinics Robert W. Summers, M.D.	Upper GI with small bowel series; Enteroscopy; Ileum biopsy	Evaluate for stricture or active Crohn's disease. <u>Im- pression</u> : Gastritis; prior ulcer disease. No active Crohn's disease; no evidence for stricture. Enteroscopy via ileal stoma showed normal ileoscopy without evidence of inflammatory bowel disease or stenosis. Ileum biopsy: No diagnostic abnormality.
07/12/98 R. 360- 65, 369	Waverly Municipal Hospital D. J. Rathe, D.O.	Weakness, clammy	<p>"I feel like crap." Pt presents with w mo. history of ileosto- my with output that does not seem to be digested at all. Symptoms started in January 1998. Pt was evaluated at the University of Iowa Hospitals. She was told to measure her outputs for four days and then begin a medicine which she mixes with Ensure. Pt is</p>

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			not sure what the medicine is and she left it at home. <u>Impression:</u> Weakness, diaphoresis with high ileostomy outputs. Pt will begin her medication regimen per Iowa City, and follow up with Dr. Berdecia in 3-5 days for urinalysis recheck.
07/13/98 R. 419	Covenant Clinic	Charley horses in legs	Pt called complaining of Charley Horses in legs for past two days and doesn't feel like doing anything. Rx for Norflex.
07/14/98 R. 366-68	Waverly Municipal Hospital Joseph Berdecia, M.D.	Diarrhea, leg cramps, weakness	Laboratory studies performed.
07/15/98 R. 418	Covenant Clinic	High output through ostomy	"They were not able to find anything wrong with her in Iowa City. She is still having problem with this." <u>Assessment:</u> 1. Leg pain, possible restless leg syndrome. 2. Possible re-exacerbation of inflammatory bowel disease. <u>Plan:</u> Rx for Skelaxin. Pt given shot of Depo Medrol.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
07/21/98 R. 418	Covenant Clinic	Abdominal cramping	Pt still having some cramping, but better since started on Levsin. “[T]hings are running right through her in the ostomy.” <u>Assessment</u> : Exacerbation of inflammatory bowel disease. <u>Plan</u> : Pt given samples of Levsin sublingual.
07/27/98 R. 418	Covenant Clinic	Ulcerative colitis and diabetes	Pt has had problems last two days with high output of her ostomy. <u>Assessment</u> : 1. Inflammatory bowel disease. 2. IDDM 3. Muscle pain in legs. <u>Plan</u> : Rx for Belladonna suppositories. Continue Levsin sublingual and Metamucil. Pt given samples of Allegra.
08/05/98 R. 417	Covenant Clinic	High output from ostomy	Pt continues to have high out- put from ostomy. Tincture of Opium did not seem to help, but she was taking too much of the medication and was given a syringe to measure it correctly. Levsin sublingual doesn’t seem to be working. <u>Assessment</u> : 1. Inflammatory bowel disease, chronic. 2. Abdominal pain, secondary to #1. <u>Plan</u> : Pt will take Tincture of Opium and Propulsid.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
08/14/98 R. 417	Covenant Clinic	High ostomy output	<u>Assessment</u> : 1. ulcerative colitis; 2. rhinitis; 3. high output from ostomy. <u>Plan</u> : Continue Propulsid and Levsin sublingual. Pt given Claritin samples.
08/27/98 R. 415	Covenant Clinic	Anxiety; follow-up re colitis	Colitis appears fairly stable at this time. Pt is having quite a bit of problem with anxiety. <u>Assessment</u> : 1. Hypertension, poor to fair control. 2. IDDM 3. Dysmenorrhea. 4. Anxiety. Rx for Alesse BCP. Increase Lotrel; continue Buspar.
09/03/98 R. 415-16	Covenant Clinic	Dizziness, dehydration, high ostomy output	<u>Assessment</u> : 1. Dehydration. 2. Colitis exacerbation. 3. Hypertension, under better control. <u>Plan</u> : Pt given one liter of lactated ringers with Phenergan. Increase Propulsid; use Tincture of Opium. Addendum: Pt sent to hospital as fluid hydration was attempted in office.
09/03/98 thru 09/04/98 R. 370-78	Waverly Municipal Hospital Joseph Berdecia, M.D.	Weakness, dizziness, nausea, high output from ostomy	Pt was given IV fluids in office, but continued not to feel well. Pt admitted to hospital for more aggressive and therapeutic intervention. Current meds: Sliding scale Humulin R, Lo-Trol, Propulsid, Levsin, Bu-Spar. Abdominal X-ray showed little bowel gas, no evidence of mechanical bowel

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			obstruction, no pneumoperitoneum. <u>Preliminary Assessment</u> : 1. Severe dehydration. 2. Exacerbation of colitis with high output of ostomy. 3. Rule out infectious process. <u>Plan</u> : Pt admitted to medical floor; given two liters of lactated ringers bolus over two hours, and Phenergan for nausea and vomiting. Cultures are negative. <u>Assessment</u> : Probably transient viral gastroenteritis.
09/05/98 R. 416	Covenant Clinic	Medication refill	Pt given four boxes of Lotrel samples.
09/10/98 R. 416	Covenant Clinic	Headache	Pt complains of headache. Tylenol gave no relief. <u>Assessment</u> : 1. Acute sinusitis 2. Colitis 3. IDDM. <u>Plan</u> : Rx for Toradol and Cefzil; refill Lotrel.
09/11/98 R. 416	Covenant Clinic	Follow-up re headache	Pt seen two days ago for acute sinusitis. Today complains of severe headache. Pt given Compazine injection and Ultram samples.
09/17/98 R. 413	Covenant Clinic	Left arm irritation	Pt developed dermatitis at IV site. She was advised to use Triamcinolone, which made symptoms worse. Rx for Medrol Dospak and liquid Vicodin; continue Allegra.
09/18/98	Waverly Municipal Hospital	Left arm pain	Pt referred to physical ther-

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
R. 379-82	Joseph Berdecia, M.D. Ron L. Ragsdale, P.T.		apy by Dr. Berdecia for evaluation of arm pain. Pt scratched her arm a few days ago, developed a rash, was told to use ointment and then wrap arm with cellophane. She complied and symptoms greatly increased; she now has general dermatitis in her forearm. There is no other type of wound dressing that would be better than the Silvadene she is using. Some Lidocaine or Marcaine could be put into the ointment to help decrease her pain.
09/21/98 R. 414	Covenant Clinic	Diarrhea	<u>Assessment</u> : 1. Chronic diarrhea. 2. Mild dehydration. Pt is to go home and drink a lot of fluids.
09/22/98 R. 413	Covenant Clinic	Medication review	Pt to use Zonic and regular dose of NPH insulin.
09/24/98 R. 413	Covenant Clinic	Headache	Pt seen for severe headache. Rx for Compazine. <u>Diagnosis</u> : Migraine headache.
09/30/98 R. 414	Covenant Clinic	Dermatitis	Pt seen for follow up of severe dermatitis on right upper extremity. <sup>7</sup> <u>Assessment</u> : 1. Dermatitis of upper extremity. 2. IDDM. 3. Ulcerative colitis. Continue Lotrel and regular insulin.

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<sup>7</sup>Previous records indicated the dermatitis was on her *left* upper arm.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
10/03/98 R. 414	Covenant Clinic	Ulcerative colitis	Pt is “sort of immunocompromise[d] because of this chronic diarrhea she has secondary to the colitis.” Pt had boils all summer, all over her body. She took Rocephin and was put on IV antibiotics. Pt has small boil on right supraclavicular area. <u>Assessment</u> : 1. Boil 2. Chronic colitis. 3. Hypertension under well control. Rx for Rocephin and Keflex. Continue hot packs.
10/05/98 R. 412	Covenant Clinic	Shoulder pain	Pt seen for complaint of shoulder pain. The area looks like a boil. <u>Assessment</u> : Carbuncle. Rx for Trovan given.
10/06/98 R. 412	Covenant Clinic	Medication reaction	Pt had a reaction to liquid Vicodin. Pt switched to liquid Motrin; Rx for liquid Benadryl for the reaction.
10/07/98 R. 412	Covenant Clinic	Follow-up re carbuncle	Pt also complains of dry skin, especially on hands. <u>Assessment</u> : Furuncle. Continue Trovan.
10/16/98 R. 412	Covenant Clinic	Medication refill	Refilled Triamcinolone, Zyllocaine, and Zinc Oxide
10/21/98 R. 411	Covenant Clinic	Itchy arm; break-through bleeding on birth control pills (Ortho-Tricyclen)	<u>Assessment</u> : 1. Dermatitis. 2. IDDM. 3. Metrorrhagia. <u>Plan</u> : Switch to Ortho-Cyclen BCP. Continue Lotrel. Increase Humulin.

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
10/28/98 R. 383-85	Waverly Municipal Hospital Joseph Berdecia, M.D.	High ostomy output; leg cramps	Pt “not feeling well.” She has been having very high output from ostomy and a lot of cramping and “charley horses” in her legs. <u>Assessment</u> : 1. Dehydration. 2. Colitis exacerbation. <u>Plan</u> : Pt given one liter of lactated ringers, Bentyl, Solu-Medrol. Pt to start Pediapred; con- tinue all other current meds.
10/29/98 R. 411	Covenant Clinic	Medical refill	Rx for Cefzil.
<b>11/01/98 R. 31, 150</b>	<b>McGee’s Claimed Disability Onset Date</b>	<b>Ileostomy for ulcerative colitis, hypertension, Type I diabetes</b>	
11/03/98 thru 11/04/98 R. 386-89	Waverly Municipal Hospital John Brunkhorst, M.D.	Diarrhea, dehydration	Pt was admitted to obser- vation bed w/diarrhea. Pt has an ileostomy and is dehydrated. <u>Assessment</u> : 1. Dehydration. 2. Insulin dependent diabetes mellitus. 3. Ulcerative colitis. Pt improved overnight and was discharged. No change in current meds; added Xanax.
11/06/98 R. 390-91	Waverly Municipal Hospital Joseph Berdecia, M.D.	Migraine headache	Pt seen in E.R.; given injections for migraine headaches. <u>Assessment</u> : Migraine headache. <u>Plan</u> : Rx for Nubain and Compazine.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
11/11/98 R. 411	Covenant Clinic	Not feeling well	Pt not feeling well. History and physical done for hospital admission.
11/11/98 thru 11/15/98 R. 392- 403	Waverly Municipal Hospital Joseph Berdecia, M.D.	Weakness	Pt lost her husband recently because of a sudden death to septicemia. Over the last few days, she has had rather large amounts of output, has not been able to eat, and feels sick, weak, and dizzy at times. Pt admitted to medical floor; started on lactated ringers. <u>Assessment</u> : Dehydration, now resolved; severe hypertension, stable; Colitis exacerbation; Diarrhea, doing better; Migraine headaches; IDDM, stable; Adjustment disorder with depressed mood. <u>Plan</u> : Ordered blood cultures and lab studies; started Pt on Solu-Medrol.
11/18/98 R. 407, 411	Covenant Clinic	High output from ostomy	Pt's blood sugars are slightly better. Switch Pt from regular insulin to Humalog to get better control of her sugars. Pt slept well in the hospital when taking Halcion. <u>Assessment</u> : 1. Hypertension. 2. IDDM poor control 3. Insomnia. <u>Plan</u> : Rx for Halcion, switch to Humalog, continue NPH. Pt to have BP checked every Friday.

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
11/19/98 R. 407	Covenant Clinic	Blood sugar too high	Pt called to report her blood sugar was too high. Pt told to increase Humalog.
11/20/98 R. 407	Covenant Clinic	Blood pressure check	BP 140/98. Rx for Demadex.
11/23/98 R. 407	Covenant Clinic	Sore throat, cough, fever	Pt called complaining of a sore, raw throat; cough; fever, for three days. Rx for Trovan.
12/02/98 R. 406	Covenant Clinic	Diabetes Mellitus	Pt's diabetes has been poorly controlled as well as her colitis. Pt is doing fairly well, but still has headaches and problems sleeping. <u>Assessment:</u> 1. IDDM. 2. Hypertension. 3. Headaches by history. <u>Plan:</u> Increase Humalog and NPH. Decrease Prozac. Continue Cardura and Lotrel.
12/04/98 R. 406	Covenant Clinic	Sinus pain	Pt called with complaints of sinus pressure and pounding. Rx for Allegra-D and Omnicef.
12/05/98 R. 406	Covenant Clinic	Pedal edema	Pt given Rx for Demadex for pedal edema.
12/07/98 R. 406	Covenant Clinic	Medication Refill	Refilled Zyrtec liquid.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
12/10/98 R. 404	Covenant Clinic	Headache	Pt complains of severe headache and feeling shaky. She has been taking Prozac and Omnicef for the last couple of weeks. <u>Assessment</u> : 1. Acute sinusitis. 2. Medication side effect. 3. Headache. <u>Plan</u> : Rx for Rocephin and Vantin; reduce Prozac.
12/16/98 R. 404-05	Covenant Clinic	Follow-up re headache	Pt still has a headache. Pt quit taking Prozac because it made her jittery. <u>Assessment</u> : IDDM, poorly controlled; acute sinusitis, better; hypertension. <u>Plan</u> : Increase Humalog, continue regular dose of NPH and Cardura, increase Demadex.
01/06/99 R. 597	Covenant Clinic	Follow-up re headache	Pt is seen for follow-up after being diagnosed with acute bronchitis, reactive airway that is doing somewhat better, and severe headaches with dizziness. <u>Assessment</u> : 1. Acute pansinusitis 2. IDDM doing somewhat better. 3. Sacroiliitis 4. Hypertension. <u>Plan</u> : Continue Lotrel, Glucophage, Humalog and Humulin N. Rx for Vantin and Kenalog spray.
01/06/99 R. 421-22	Covenant Clinic Joseph Berdecia, M.D., Ph.D.	Letter to Mayo Clinic	Referral to the Mayo Clinic for evaluation of problems with high output of Pt's ostomy.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
01/08/99 R. 596	Covenant Clinic	Coughing, chest pain, headache	<u>Assessment</u> : 1. Acute bron- chitis 2. RAD. 3. Pan- sinusitis. <u>Plan</u> : Pt given Rocephin and breathing. Rx for Atrovent, Albuterol, and Vanceril double strength. CT confirmed acute sinusitis in right asthenoid, right and left maxillary sinuses.
01/09/99 R. 596	Covenant Clinic	Follow-up re bronchitis	Pt came in for a repeat Rocephin injection. She appears to have better air movement.
01/11/99 thru 01/12/99 R. 423, 625-26, 629-30	Waverly Municipal Hospital Joseph Berdecia, M.D., Ph.D.	Dehydrated	Pt "not feeling well." Pt was admitted after failing out- patient treatment and becoming quite dehydrated because of high ostomy output. <u>Assessment</u> : 1. Acute bronchitis 2. Failed out- patient treatment. 3. Acute pansinusitis. 4. High ostomy output decreased. 5. Reaction airway disease, doing better. <u>Plan</u> : Pt discharged home to continue with respiratory treatments. She will continue as an outpatient with IM antibiotic treatments. Start on Flonase nasal spray.

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
01/13/99 R. 596, 632	Covenant Clinic	Follow-up re bronchitis; ankle and knee sprain	Pt doing fairly well after hospitalization. Pt sprained her ankle and knee. Pt still having problems with head- aches, still using her respira- tory machine. Chest X-ray: Very shallow inspiration probably related to Pt's size. Heart size normal. Lungs clear. <u>Assessment</u> : Acute bronchitis; Pansinusitis.
01/14/99 R. 596	Covenant Clinic	Follow-up re bronchitis & sinusitis	Pt returns for follow-up; also had problems with vomiting today. <u>Assessment</u> : 1. Acute bronchitis 2. Pansinusitis. 3. Nausea. <u>Plan</u> : Pt given Compazine and Rocephin.
01/15/99 R. 424	Covenant Clinic Joseph Berdecia, M.D. Ph.D.	Letter to Iowa Department of Transportation	Pt's handicap is permanent. <u>Diagnosis</u> : IDDM, severe hypertension, colitis.
01/15/99 R. 595	Covenant Clinic	Follow-up re bronchitis and sinusitis	Pt still having severe headaches. Stadol is the only thing that controls her pain. Pt given injection of Rocephin. Scheduled follow- up CT. Refilled Stadol.
01/16/99 R. 595	Covenant Clinic	Follow-up medication	Pt came in for a shot of Rocephin per Dr. Berdecia's order.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
01/17/99 thru 01/19/99 R. 425- 33, 631	Waverly Municipal Hospital Lee Fagre, M.D.	Dehydration	Pt was admitted with gastroenteritis. Pt was rehydrated and her insulin dependent diabetes mellitus was treated. Pt's bowels were slowed down a bit. <u>Final Diagnosis</u> : 1. Gastroenteritis 2. Dehydration, improved. 3. Insulin dependent diabetes mellitus. 4. Status post ileostomy with dumping syndrome. 5. Acute sinusitis resolving. 6. Resolving bronchitis. 7. Hypertension. <u>Plan</u> : Metamucil wafers, Lomotil liquid, Humulin, Humalog, Glucophage, Lotrel, ACE inhibitor.
01/22/99 thru 01/23/99 R. 434- 39, 627	Waverly Municipal Hospital Joseph Berdecia. M.D.	Weak, headache	Pt had been doing well last few days until 01/21, when she started having multiple episodes of high output through her ostomy, and headache. <u>Assessment</u> : 1. Orthostatic hypotension. 2. Dehydration. 3. Pansinusitis. 4. IDDM. <u>Plan</u> : Pt given one liter of lactated ringers; put on full liquid ADA diet of 1800 calories; restarted on Zosyn; restarted her home meds.
01/25/99 R. 440- 46, 621- 23, 627	Waverly Municipal Hospital Joseph Berdecia, M.D.	Laboratory results	Diagnosis: Hypotension, hypokalemia, IDDM, colitis, old ostomy.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
01/25/99 R. 595	Covenant Clinic	Vomiting, back pain	Pt threw up all day yesterday and is having some back pain. Pt's lab studies showed low potassium and abnormal urinalysis. <u>Assessment</u> : 1. Hypokalemia. 2. Urinary tract infection. <u>Plan</u> : Pt given Rocephin and Toradol for headache. Rx for Ceftin and K-Dur.
01/26/99 thru 01/29/99 R. 449-57	Mayo Clinic	Evaluation	Chief complaint: Severe dehydration with high output from ileostomy. <u>Summary Diagnoses</u> : 1. Increased ileostomy output, secondary to bacteria overgrowth and excessive intake of simple carbohydrates. 2. Dehydration, secondary to #1. 3. Diabetes mellitus type 2. 4. History of ulcerative colitis, status post total colectomy with ileostomy.
01/29/99 R. 447-48	Mayo Clinic Lisa A. Boardman, M.D.	Report from evaluation at Mayo Clinic	Pt was admitted to Gastroenterology Service at Mayo Medical Center. Reviews Pt's history of high output through stoma and dehydration. "It was believed that the portion of the increased stool output that was associated with dehydration was related to her diet." Pt instructed in use of "Ceralyte," and magnesium and potassium replacements. Pt told to follow diabetic diet more

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			carefully. Pt to measure stool output on a daily basis. Bacterial overgrowth is likely a component of her increased stool frequency, and Pt was started on ciprofloxacin. Pt “may need to be on this chronically, but after three months of antibiotic therapy, she will have a trial without antibiotics to determine the need for long-term antibiotic treatment.” Recommended discontinuing Glucophage because it may aggravate diarrhea. Pt’s electrolyte imbalance was felt to be related to the increased output through her stoma.
01/29/99 R. 594	Covenant Clinic	Medication Refill	Rx for Amitriptyline.
01/30/99 thru 01/31/99 R. 458- 68, 619- 20	Waverly Municipal Hospital Joseph Berdecia, M.D.	Weakness, hypertension	Pt was admitted with problems with hypertension, low borderline potassium, low magnesium level. Pt given an IV fluid bolus followed by IV magnesium and potassium supplementation. Restarted meds. <u>Assessment</u> : 1. Dehydration. 2. Orthostatis hypertension 3. Electrolyte imbalance. <u>Plan</u> : Pt to have IV hep locked; change her electrolyte at home to K-Dur, continue Mag Sulfate supplementation and her other meds.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
02/02/99 R. 594, 617	Covenant Clinic	Dehydration	Pt had to be hospitalized “after getting dehydrated after being up all [night] at a concert.” Pt advised “to take better care of herself.” <u>Assessment</u> : 1. Hypertension 2. IDDM 3. Dehydration doing better. Rx for K-Tabs. Mayo recommended cycling Pt with Cipro, Amoxicillin and Bactrim.
02/08/99 R. 469- 70, 616	Waverly Municipal Hospital Joseph Berdecia, M.D.	Lab results	
02/09/99 thru 02/10/99 R. 471- 77, 613- 14	Waverly Municipal Hospital Joseph Berdecia, M.D.	Vomiting, abdominal pain	Pt was admitted with nausea, vomiting, and not feeling well. Pt rehydrated with IV fluid; showed increase in her creatinine levels for first time. Recommended that Pt have some counseling and possibly a psychiatric evalua- tion for depression. Renal ultrasound was negative. <u>Assessment</u> : 1. Colitis exa- cerbation 2. Diarrhea. 3. Dehydration. 4. Uremia. <u>Plan</u> : Continue workup for kidney problems on out- patient basis. Schedule appt at Cedar Valley Mental Health for further counseling and treatment. Pt to resume home meds except for Lotrel. Rx for Serzone, Asacol, Potassium chloride liquid, and Atarax.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
02/12/99 R. 478, 481-83	Waverly Municipal Hospital Francis Coyle, M.D.	Abdominal pain	Pt complains of abdominal pain. Given Demerol and Vistaril.
02/13/99 R. 479- 80, 488, 612	Allen Memorial Hospital Suresh K. Reddy, M.D.	Abdominal pain, vomiting, increased ostomy output	Pt seen in E.R. at Waverly Hospital for acute onset of abdominal pain, vomiting, and increased output from her ostomy. Pt given IV fluids, Demerol, and Vistaril; transferred Pt to Allen Memorial Hospital for further management of symptoms. By the time Pt got to Allen Memorial Hospital, her symptoms were better. <u>Impression:</u> 1. Intermittent episodes of abdominal pain, nausea, vomiting and diarrhea causing dehydration. Etiology unclear. Pt diagnosed w/bacterial overgrowth which could be causing her symptoms. 2. History of ulcerative colitis, status post colectomy with ileostomy. <u>Plan:</u> Rx for Cipro. Drink electrolyte solutions such as Pedialyte or Gatorade. Limit intake of fluids to 1.5 to 2 liters a day.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
02/17/99 R. 593	Covenant Clinic	Follow-up re abdominal pain	Pt feeling somewhat better today, but still having problems with output. <u>Assessment</u> : 1. Bacterial overgrowth of gastric fluid. 2. IDDM, w/sugars between 90 and 150. 3. Adjustment disorder with depressed mood. 4. Headaches by history. <u>Plan</u> : Stay on Cipro. Pt given samples of Phrenilin Forte. Continue Serzone, Lotrel, Prevacid, Magnesium supplementation and hypopotassium supplementation. Pt given one spray of Stadol nasal spray for severe headache; may repeat in one hour with one refill.
02/24/99 R. 592	Covenant Clinic	Swollen legs	Pt has been developing problems with leg edema. <u>Assessment</u> : 1. Leg edema. 2. Hypertension 3. IDDM. <u>Plan</u> : Pt given Humulin Pen to use. Rx for Neurontin. Juzo stockings were ordered.
02/24/99 R. 484	Covenant Clinic Joseph Berdecia. M.D., Ph.D.	Letter to Meyer Pharmacy	Recommendation for Pt to use compression hose to prevent complications from Chronic Venous Stasis.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
03/02/99 R. 485	Cedar Valley Mental Health Center Pat Jebe, LMHC	Report from mental health evaluation	Counselor met w/Pt twice. Pt appears to be struggling with some grief over husband's death. Pt continues to take Serzone; sees no changes but reports she feels quite well. It has been over three weeks since she has felt the need to be hospitalized. Pt "does appear to be very active and seems to have many interests/projects going on at this time." Scheduled follow-up.
03/03/99 R. 592	Covenant Clinic	Hypertension, diabetes, edema	Pt feeling better, but still staying up at night. <u>Assessment</u> : 1. Hypertension 2. IDDM. 3. Pedal edema. 4. Adjustment disorder. <u>Plan</u> : Continue Juzo hose. Rx for Avapro. Increase Serzone.
03/10/99 R. 591, 611	Covenant Clinic	Abdominal pain	Pt complaining of severe low abdominal pain over the ovaries, that goes around to her back. <u>Assessment</u> : 1. Abdominal and pelvic pain. 2. Sinusitis. <u>Plan</u> : Rx for Toradol, Rocephin, Flagyl. Scheduled Pelvic CT.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
03/12/99 R. 486- 87, 489	Waverly Municipal Hospital Joseph Berdecia, M.D.	Radiology report from pelvic CT	CT of pelvis without contrast. <u>Opinion</u> : "There is a questionable indistinctness in the mid pelvis at the uterine fundus that is probably simply due to adjacent fluid filled bowel loops. It would seem unusual that if this were free fluid that it does not accumulate in a more dependent portion of the posterior pelvis. An ileostomy is identified. I do not identify abnormal bowel wall thickening." Addendum to CT: Comparison with pre- vious Mayo Clinic exam shows no remarkable change in appearance of the pelvis.
03/19/99 R. 590	Covenant Clinic	Pelvic pain	Pt still having pelvic pain. Pelvic CT did not show any masses. Pt having some unusual headaches. <u>Assess- ment</u> : 1. Pelvic pain 2. Rhinitis. 3. Hypertension <u>Plan</u> : Continue Avapro. Rx for Nasonex and Micronor.
03/22/99 R. 591	Covenant Clinic	Upper quadrant pain	Pt complaining of constant, dull upper quadrant pain, and occasional sharp pain. Persistent headache. No treatment notes.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
03/23/99 R. 590	Covenant Clinic	Pelvic pain; knee and joint pain; breathing problems	Pt complains of having some difficulty with her breathing and still having some pelvic pain. Xanax helps Pt sleep. Pt having a lot of knee pain and joint problems. Celebrex helped with the joint pain. <u>Assessment</u> : 1. Acute reactive airway disease. 2. IDDM. 3. Pelvic pain. <u>Plan</u> : Rx for Celebrex, Xanax, Vicodin ES, Progesterone tablet. Continue Humalog, Micronor tablet.
03/29/99 R. 494- 501	John A. May, M.D.	Physical Residual Functional Capacity Assessment	Pt may lift and/or carry 50 lbs, including upward pulling, <u>occasionally</u> and 25 lbs <u>frequently</u> ; stand and/or walk about 6 hrs in an 8-hr workday (with normal breaks); sit about 6 hrs in an 8-hr workday (with normal breaks); and is unlimited in her ability to push and/or pull (including operation of hand and/or foot controls), other than as shown for lift and/or carry. Pt has no postural, manipulative, visual, communicative or environmental limitations.
03/29/99 R. 502-03	John A. May, M.D.	Medical Consultant Review	Pt "alleges ileostomy, ulcerative colitis, hypertension and diabetes mellitus." Medically determinable impairment is ulcerative colitis with ileostomy, hypertension,

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			<p>diabetes mellitus, Type II and obesity; severe based on impairment findings, symptoms, and consistency of evidence. Pt has migraine headaches, abdominal cramps, swelling of legs, and less energy than she used to have. <u>Current meds:</u> Serzone, Neurontin, Prevacid, Accupril, Phenergan, Stadol, insulin, Naprosyn and Prozac. "The claimant's allegations are consistent and credible."</p> <p><u>Conclusion:</u> "This claimant has a long history of colitis with ileostomy in the late 70's. This was revised in 2/98. She has been hospitalized in 1998 due to diarrhea and dehydration. Her weight and hemoglobin have remained stable. GI studies reveal no recurrence of her colitis. She has diabetes mellitus, hypertension, and migraine headaches which are controlled by medication. She is currently taking care of children in her home. No limitations have been placed by her treating sources."</p>

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
03/30/99 R. 504	Covenant Clinic Preeti Srivatsa, M.D.	Report from evaluation for pelvic pain and irregular menses	Pt referred for evaluation. Exam was unremarkable. Pt given samples of Voltaren; recommended possible Depo Provera or Provera to control bleeding.
04/07/99 R. 589	Covenant Clinic	Crying spells	Pt complains there is “something wrong with her.” Pt took father- and mother- in-law to cemetery last week to look at her husband’s grave. Since then, Pt has had difficulty sleeping and has frequent crying. Pt still having difficulty dealing with her husband’s sudden death. <u>Assessment</u> : 1. Adjustment disorder with depressed mood. <u>Plan</u> : Switch to Zoloft, increase Xanax.
04/08/99 R. 589	Covenant Clinic	Medication Refill	Rx for Demadex, Prevacid.
04/12/99 R. 589	Covenant Clinic	Blisters on arm	Pt has scratch on forearm that she has rubbed and now has an open blister, like sunburn. <u>Assessment</u> : Cellulitis from scratch on left forearm. <u>Plan</u> : Dressed Pt’s arm with Bactroban, which she didn’t like, so Rx for Silvadene was given to Pt.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
04/15/99 R. 588	Covenant Clinic	Medication Refill	Pt requested refill on Stadol Nasal Spray. Meyer Pharmacy called to state Pt had got gotten a refill seven days ago and Dr. only wanted her to refill it every two weeks. Pt was told to make it last until the end of the week.
04/22/99 R. 588	Covenant Clinic	Medication Refill	Rx for Hydrocodone/Apap.
04/27/99 R. 588	Covenant Clinic	Elevated blood sugar	Pt is on Danazol for dysmenorrhea; Danazol is raising Pt's blood sugars. <u>Assessment</u> : 1. IDDM poorly controlled. 2. Dysmenorrhea better but still having pain. 3. Headaches. <u>Plan</u> : Rx for Zomig and Nasonex spray. Increase Humulin-N, Humalog, and Zoloft.
04/27/99 R. 588	Covenant Clinic	Headache	Pt comes in for a second visit today complaining of headache. Zomig caused a lot of burning and shooting pain. The only way to get rid of the headache was to give Pt Nubain and Vistaril. Pt told not to take Zomig.
04/28/99 R. 588	Covenant Clinic	Headache	Pt called to report she woke up with a terrible headache. Zomig did not help. Danazol dose was cut in half and Stadol spray refilled.

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
04/29/99 R. 587	Covenant Clinic	Severe headache, burning in face	Pt told to use Stadol now, and again in one hour if not better.
04/30/99 R. 587, 607, 609- 10	Covenant Clinic	Headache	Pt called stating her headache was back. She has used eight squirts of Stadol since 3:30 p.m. yesterday with no relief. "Faxed golden rod to WMH for Solu Medrol 100 mg IM, Nubain 20 mg IM and Compazine 10 mg IM." Pt scheduled for EEG, MRI of head, lab studies. Pt given Nubain and Vistaril.
04/30/99 R. 505-10	Waverly Municipal Hospital Joseph Berdecia. M.D.	Headache	Pt went to E.R. with "headache since yesterday." Pt given Solu Medrol, Nubain and Compazine. Pt instructed not to drive; go home and rest.
05/03/99 R. 587	Covenant Clinic	Headache	Pt having intractable head- aches. Pt counseled con- cerning her use of Stadol, which is only medication that seems to help. Pt will try Fiorinal with codeine.
05/03/99 R. 587	Covenant Clinic	Medication Refill	Pt called requesting more Stadol, still complaining of terrible headache. Pt has filled eight bottles of Stadol in March and seven bottles in April. Rx for Fiorinal with codeine
05/04/99 R. 587	Covenant Clinic	Medication Refill	Rx for Topicort, Lidocaine, Zinc Oxide Cream.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
05/04/99 R. 586	Covenant Clinic	Nausea	Pt presents feeling shaky and nausea, hurts all over, feeling hot and cold at times. <u>Assessment</u> : 1. Acute sinusitis. 2. Headaches recurrent. <u>Plan</u> : Rx for Depo Medrol, Rocephin, and Toradol.
05/05/99 R. 511-13	Waverly Municipal Hospital Joseph Berdecia, M.D.	Report from MRI of head and EEG	MRI of head with and without contrast was normal. EEG normal, awake and asleep.
05/07/99 R. 514-15	Cedar Valley Medical Specialists, P.C. Brian Sires, M.D.	Headaches	Pt seen for evaluation of severe headaches which historically seem to be related to hormone manipulation for her menstrual periods. Also possible muscle contraction component. Recommended Pt's hormones be changed or discontinued. Pt sent to physical therapy for massage techniques.
05/09/99 R. 516-18	Waverly Municipal Hospital David J. Rathe, M.D.	Headache, irregular and elevated blood sugars, dizziness, depression	Pt has no vision disturbance, though she is photophobic and phonophobic with headaches. Pt has difficulty sleeping due to headaches. Pt has been under stress recently and in recent past; husband died 11/98. Pt has been having problems with depression and has been scratching herself until she bleeds. <u>Meds</u> : Zoloft, Percocet, Cipro, insulin Humulin, Humalog and

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			Regular. <u>Impression</u> : 1. Chronic cephalgia with acute exacerbation. 2. Diabetes Type II, elevated glucose. <u>Plan</u> : Pt to use her own headache pill; return to E.R. if headaches worsen.
05/10/99 R. 586	Covenant Clinic	Arm itching	Pt has scratched her arms with scissors because they were bothering her so much. <u>Assessment</u> : 1. Dermatitis. 2. Cellulitis of the upper extremity. <u>Plan</u> : Rx for Keflex. Pt given a mix of Triamcinolone/Silvadene to apply to affected areas.
05/11/99 R. 586	Covenant Clinic	Medication Refill	Rx for Phrenilin Forte.
05/12/99 R. 586	Covenant Clinic	Medication Refill	Rx for Topicort, Lidocaine, Zinc Oxide Cream.
05/13/99 R. 519-22	Waverly Municipal Hospital Joseph Berdecia, M.D.	Headache	Pt went to E.R. with complaints of headache all over her head. MRI of head was normal.
05/14/99 R. 585	Covenant Clinic	Headache	Pt has "terrible headache"; does not feel well. <u>Assessment</u> : 1. Headache. 2. muscle cramps. 3. Ileostomy because of severe colitis. 4. Adjustment disorder. <u>Plan</u> : Rx for Xanax, Stadol, Vistaril, Neurontin; increase Avapro.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
05/20/99 R. 585	Covenant Clinic	Follow-up re hypertension, diabetes	<u>Assessment</u> : 1. Hypertension 2. Colitis. 3. IDDM. <u>Plan</u> : Rx for Cipro, Avapro. Continue insulin dosage. Pt is off Danazol and her sugars are coming down.
05/26/99 R. 585	Covenant Clinic	Sore throat	Pt complains of sore throat, sinus congestion and pressure. Rx for Cefzil and Pan Mist LA.
06/02/99 R. 585	Covenant Clinic	Medication	Rx for Vistaril and Stadol. Increase Levoxyl.
06/07/99 R. 584	Covenant Clinic	Nasal drainage	Pt still having problems with colitis. Exam shows red throat and "copious amounts of postnasal drainage." Refilled Kenalog spray; continue other current meds.
06/08/99 R. 581, 583, 584	Covenant Clinic	Medication	Given Rx for "Palgic DS" for nasal problems and sinus.
06/08/99 R. 584	Covenant Clinic	Medication Refill	Rx for Tincture of Opium.
06/09/99 R. 581, 583	Covenant Clinic	Medication	Rx for Phrenilin Forte and "Palgic DS."
06/15/99 R. 581, 583	Covenant Clinic	Medication Refill	Rx for Lotrisone Cream, Phrenilin Forte, Hydroxyzine Syrup.
06/18/99 R. 581, 583	Covenant Clinic	Headache and nausea	Phrenilin Forte not helping. Rx for Compazine.

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
06/26/99 R. 581, 583	Covenant Clinic	Medication Refill	Rx for Phrenilin Forte.
06/28/99 R. 581	Covenant Clinic	Headache	Pt is seen for follow up on diabetes; complains of frequent headaches and menstrual pain. <u>Assessment</u> : 1. IDDM stable. 2. Migraine headaches. 3. Hypertension 4. Dysmenorrhea. <u>Plan</u> : Take Prempro and Phrenilin Forte.
06/28/99 R. 584	Covenant Clinic	Medication	Rx for liquid KCL
07/07/99 R. 582	Covenant Clinic	Medication Refill	RX for Stadol Nasal Spray.
07/08/99 R. 581, 583	Covenant Clinic	Medication Refill	Rx for Tincture of Opium and Silvadene.
07/12/99 R. 582	Covenant Clinic	Medication Refill	Rx for Tincture of Opium.
07/27/99 R. 523- 530	Gary J. Cromer, M.D.	Physical Residual Functional Capacity Assessment	<u>Exertional Limitations</u> : Pt may lift and/or carry 20 lbs, including upward pulling, <u>occasionally</u> and 10 lbs <u>frequently</u> ; stand and/or walk about 6 hrs in an 8-hr work-day (with normal breaks); sit about 6 hrs in an 8-hr work-day (with normal breaks);and is unlimited, in her ability to push and/or pull (including operation of hand and/or foot controls) other than as shown for lift and/or carry. <u>Postural</u>

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
			<u>Limitations</u> : Pt can <u>occasionally</u> climb ramps/stairs, balance, stoop, kneel, crouch and crawl. Pt cannot climb ladders/ropes/ scaffolds. No other limitations.
07/27/99 R. 531-32	Gary J. Cromer, M.D.	Medical Consultant Review Comments	Pt “alleges disability due to ileostomy for ulcerative colitis, hypertension, diabetes, and back pain from arthritis. AOD is 11/01/98.” <u>Conclusions</u> : “Claimant has documented medically determinable impairments with history of ulcerative colitis now status post total colectomy without extraintestinal manifestations, moderate obesity, diabetes and hypertension and headaches. Her diabetes and hypertension are nonsevere. She has not documented a medically determinable impairment to support her allegation of back pain from arthritis.” Remaining impairments are severe but do not meet listing requirements. “Subject reports reveal numerous inconsistencies. Claimant has a history of dietary noncompliance that was determined to be the primary factor in causing her GI symptoms.” Pt has gained 25 pounds. “She has exhibited drug-

<b>DATE</b>	<b>MEDICAL PRACTITIONER/ FACILITY</b>	<b>COMPLAINTS</b>	<b>DIAGNOSIS, TREATMENT &amp; COMMENTS</b>
			seeking behavior and overuse of narcotics, and has been noncompliant in following up with her neurologist regarding her headaches. These inconsistencies have eroded claimant's credibility."
08/10/99 R. 580	Covenant Clinic	Medication Refill	Rx for Amoxil.
08/18/99 R. 580	Covenant Clinic	Medication Refill	Rx for Nystatin Swish and Swallow.
08/18/99 R. 533-36	Glenn F. Haban, Ph.D.	Psychological Evaluation	Pt referred for evaluation to help determine eligibility for Social Security Benefits. Pt arrived on time, dressed casually, and was neat and clean with good hygiene. Weight somewhat above average for her height. Steady gait. "Numerous scratches and sores were noted on her left forearm." "No unusual thought content or preoccupations were expressed." Affect was appropriate; "social presentation was somewhat dramatic." "The results of the cognitive status screening found Ms. McGee to be within the normal range for orientation and elemental cognitive capacity. She was grossly intact for simple attention processes, but borderline for more complex

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			<p>attention and problem solving skills. Her functioning was intact for memory functioning, verbal similarities and differences, performs mathematical calculations. She was intact for abstract reasoning and concept formation.” Pt “is currently functioning within the normal range for orientation and cognitive capacity. The mental status examination suggests bereavement. No other Axis One Disorders were identified.” Pt can manage her own funds. <u>Ratings of job-related skills</u> - in the following areas: concentration/attention and calmness/patience are poor to adequate; self-confidence is poor; social skills and dealing with public are adequate to excellent; taking supervision is excellent; work stresses, independence, making decisions, handling money, understanding complex job instructions, reliability, persistence, and accuracy in work are all adequate. [Excellent means no impairment. Adequate means “Performs well enough to meet community-work expectations.” Poor means “Is impaired to the extent that</p>

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			<p>behavior is not dependable or c[onsistent].”]</p> <p><u>Tests Administered:</u> Mental Status Checklist for Adults; Cognitive Capacity Screening Examination.</p> <p><u>Clinical Interview:</u> Pt reports she is unable to work due to nervousness and mood changes that have increased since her husband died last year. Pt continues to be involved in pleasurable activities such as going to the fair, visiting with others, and cooking, but her activity is limited by pain. Pt has 10 years of formal education and a GED. She quit school due to medical problems. Pt was trained as a nursing assistant, but quit due to back injury and difficulty working with older patients, who would die. Pt worked in child care for the past 4 years and was able to care for about 10 children. “She feels she can no longer do this job due to her nervousness. She continues to care for one child on a part-time basis. She is not looking for work and feels unable to work due to her emotional condition.”</p>

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08/25/99 R. 537	Jay P. Ginther, M.D.	Epicondylitis	Pt had good results with injections to right medial epicondylar area along with using a brace and taking Ibuprofen on a regular basis. Pt is doing well on the right overall. Left medial epicondyle is tender; Pt has multiple areas of abrasion on the dorsum of the left forearm from scratching. She has been scolded for this by the Medi Health counselor. <u>Plan</u> : Inject left medial epicondylar area with Marcaine and Depo-Medrol. She was given a brace and refilled her Ibuprofen.
08/25/99 R. 580	Covenant Clinic	Medication Refill	Rx for Amoxil.
08/26/99 R. 580, 608	Covenant Clinic	Cat bite	Pt got bitten by her cat. Rx for Amoxicillin.
08/31/99 R. 642	Waverly Municipal Hospital Dawn Morey, D.O.	Spots on stoma	Pt is seen for bleeding spots on stoma, present for several weeks. Ostomy appliance does not fit well and leaks occasionally, although output is much better. <u>Assessment</u> : Granulation tissue on the ostomy with bleeding. Ulcerative colitis. <u>Plan</u> : Pt to see ostomy nurses for possible change in stoma appliance.

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09/01/99 R. 580	Covenant Clinic	Medication Refill	Rx for Stadol Nasal Spray
09/02/99 R. 548, 642	Dawn Morey, D.O.	Report from referral re granulation tissue on ostomy	Pt seen because of granulation tissue on ostomy that bleeds. Appliance removed; several areas excised and sutured. Pt to follow up with ostomy nurse to get a better fitting ostomy appliance.
09/24/99 R. 679	Covenant Clinic Joseph Berdecia, M.D., Ph.D.	Opinion ltr to Pt's attorney	Pt has "extensive medical problems" including severe hypertension, insulin dependent diabetes, and colitis since age 16. Pt has bouts of multiple problems that include chronic and persistent diarrhea requiring multiple hospitalizations over the past two years, with developing severe problems with electrolyte imbalance. Pt is on multiple meds for treatment of these conditions as well as headaches. Dr. opines Pt will be unable to obtain employment due to frequent absences from work to deal with her medical problems.
09/30/99 R. 571- 572, 604- 05	Waverly Municipal Hospital John Halloran, M.D.	Report from gallbladder ultra- sound	<u>Impression:</u> 1. cholelithiasis without ultrasonographic evidence of cholecystitis. 2. No evidence of biliary ductal dilatation. 3. Probable diffuse fatty infiltration of the liver.

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10/01/99 R. 573	Allen Memorial Hospital Lawrence Liebscher, M.D.	Report from NM Hepatobiliary scan	<u>Impression</u> : 1. No evidence for acute cholecystitis. 2. Low gallbladder ejection fraction which is a nonspe- cific finding but could be secondary to chronic chole- cystitis or biliary dyskinesia.
10/04/99 R. 579	Covenant Clinic	Medication Refill	RX for Tincture of Opium and Hydrocodone.
10/04/99 R. 539-47	Beverly Westra, Ph.D.	Psychiatric Review Technique	Pt has disturbance of mood, accompanied by a full or partial manic or depressive syndrome as evidenced by a diagnosis of adjustment dis- order with depressed mood. Pt has a <u>slight</u> degree of limi- tation in activities of daily living and difficulties in maintaining social function- ing. Pt <u>often</u> has deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (in work settings or elsewhere). Pt <u>never</u> has episodes of deterioration or decompensation in work or work-like settings.
10/04/99 R. 551-54	Beverly Westra, Ph.D.	Mental Residual Functional Capacity Assessment	Pt is <u>moderately limited</u> in ability to understand, remem- ber, and carry out detailed instructions; maintain atten- tion and concentration for extended periods. Pt is <u>not</u> <u>significantly limited</u> in any other area.

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10/04/99 R. 555	Beverly Westra, Ph.D.	Medical Consultant Review Comments	Pt alleges disability due to ileostomy, ulcerative colitis, hypertension, diabetes mellitus; after filing initial claim, had treatment for depressed mood by family physician, and consultative exam on 8/18/99. Family doctor diagnosed Adjustment Disorder with Depressed Mood shortly after death of Pt's husband. Dr. Haban assessed Pt on 8/18/99, and diagnosed Bereavement 9 mos after her husband's death. This doctor feels Adjustment Disorder with Depressed Mood (chronic) would be the most appropriate diagnosis. No evidence of limitations re activities of daily living or social functioning. "Attention and concentration would be adequate for most simple tasks, but moderately impaired for highly complex or detailed information and for sustained attention for prolonged periods of time." <u>Conclusion</u> : Pt has medically determinable impairment of Adjustment Disorder with Depressed Mood, severe, but not of listing-level severity. Impairment results in some mild to moderate limitations. "Allegations are credible and consistent[.]"

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10/04/99 R. 570	Covenant Clinic John B. Brunkhorst M.D.	Referral	Referral to Dr. Morey for evaluation and treatment of gallstones.
10/07/99 R. 549-50	Dawn Morey, D.O.	Report from evaluation re abdominal pain	Pt seen for abdominal pain that began suddenly last week when Pt was in the bathtub. Pt got nauseated suddenly and began throwing up profusely. Pt was taken to E.R. and admitted for work up. Pt continues to have pain in right upper abdomen, radiating through to her back and somewhat up into her chest. Ultrasound shows cholelithiasis. <u>Assessment</u> : Cholelithiasis, cholecystitis. <u>Recommendation</u> : Cholecystectomy with cholangiogram.
10/08/99 R. 556-58, 569	Waverly Municipal Hospital Dawn Morey, D.O.	Cholecystectomy	Post-op Diagnosis: Cholelithiasis, cholecystitis
10/19/99 R. 640-41	Waverly Municipal Hospital Dawn Morey, D.O.	Post-op check	Pt is doing fairly well. Recheck in a month and order liver function tests at that time. <u>Assessment</u> : Status post open cholecystectomy.
10/22/99 R. 578-79, 602	Covenant Clinic	Not feeling well; crying for three days	Pt is just not feeling well; husband died one year ago. "This time of year I would expect her to have these feelings of depression and sadness." Pt sent to Mental Health Center. Pt would like something for sleep as the

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			Ambien is not working and would like to be evaluated as to why she hasn't had a period for over a year. <u>Assessment</u> : Insomnia, secondary to depressive affect. She also has amenorrhea. Pt to continue current meds. Rx for Restoril.
10/25/99 R. 578	Covenant Clinic	Post-operative pain	Pt has pain in lateral aspect of the surgical wound she got from the cholecystectomy. <u>Assessment</u> : Post-op hematoma. Pt given Percocet.
10/28/99 R. 640	Waverly Municipal Hospital Dawn Morey, D.O.	Incisional pain	Pt is evaluated for pain in lateral aspect of her incision. Dr. Skierka injected a local which helped discomfort temporarily. <u>Assessment</u> : Abdominal wall tenderness, status post open cholecystectomy. <u>Plan</u> : Recommended ultrasound to rule out hernia. Ultrasound shows a 6 mm area of fluid collection at site of tenderness; looks homogeneous and was injected with some local anesthetic. Pt to take Motrin liquid and take it easy for a few days.

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10/30/99 R. 568	Waverly Municipal Hospital Lee Fagre, M.D.	Pain in incision	Pt seen for pain in the incision along the lateral aspect. Area has been injected twice and ultrasound showed no gross abnormalities. Small palpable mass along gallbladder scar was injected with Marcaine. "I think she needs a pain doctor to take care of it."
11/01/99 R. 559- 64, 639	Waverly Municipal Hospital Dawn Morey, D.O.	Placement of L internal jugular Titan port	Pt has difficulty with IV access. Post-op Diagnosis: Need for long term IV access, right upper quadrant incisional pain. Pt had a port placed this morning and developed a rash, itching and general anxiety with pain in the left lateral incision. It was recommended the Pt see a GI specialist to evaluate the cholangiogram pictures and abnormal liver function tests.
11/01/99 R. 567	Waverly Municipal Hospital Driss Cammoun, M.D.	Chest X-ray	Portable Chest X-ray: Left jugular line with the distal segment is difficult to identify but could project near the SVC. No pneumothorax. Lungs are low volume. Heart is of normal size. Pulmonary vascularity is normal. No evidence for pleural disease.

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11/04/99 R. 565	Covenant Clinic Matt Sowle, PA-C	Consult request	A consult was requested for Pt with Dr. Federhofer for right-sided pain at incision site.
11/04/99 R. 566, 601	Covenant Clinic Matt Sowle, PA-C	Consult request	A consult was requested for Pt with Dr. Reddy re abdominal pain.
11/06/99 R. 666	Waverly Municipal Hospital Branimir Catipovic, M.D.	Headaches	Pt has history of multiple headaches. Recently she got a porta cath because of her need for IV medication. She had a very bad headache treated with Vistaril and Demerol. <u>Current meds:</u> Celebrex, Luvox, Neurontin, Avapro, Prevacid, Ambien, Cipro, Demadex, Magnesium, Phrenilin, insulin. <u>Assessment/Plan:</u> Headache. Pt will be given Vistaril and Demerol.
11/08/99 R. 577	Covenant Clinic	Sore throat, cough, earache, no fever	Pt called in to report symptoms. Rx for Suprax.
11/09/99 R. 639	Waverly Municipal Hospital Dawn Morey, D.O.	Port check	Pt is seen for check of a port that was placed recently. No evidence of infection.
11/10/99 R. 577	Covenant Clinic	Headache	Pt complains of bad headache radiating around to the front of her head. She is not having blurred vision now, but did earlier in the day. Pt given an injection of Toradol.

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11/12/99 R. 638	Waverly Municipal Hospital Dawn Morey, D.O.	Fluid hydration	Pt in for fluid hydration. Swelling and pain were noticed at the port site. <u>Assessment</u> : Extravasation, most likely from dislodged Huber needle. <u>Plan</u> : Let swelling go down and reevaluate.
11/15/99 R. 638	Waverly Municipal Hospital Dawn Morey, D.O.	Evaluation of port	Pt in for re-evaluation of port. Swelling is gone and port is easily accessed. Scheduled portogram contrast study.
11/15/99 R. 576	Covenant Clinic	Medication Refill	Refilled Cipro
11/15/99 R. 576	Covenant Clinic	Dizziness, headache	Advised Pt to take Valium for the dizziness. Refilled Valium. Pt to see Dr. Morey today.
11/16/99 R. 576	Covenant Clinic	Blood pressure check	BP 140/98. In light of Pt's headaches, she was started on Propranolol. Pt also has rash on left arm which she scratched and it has broken out. She was given samples of Bactroban, Maxalt, and Imitrex. Triamcinolone ointment and cream was also used. Extensive workup was done including CT scan and MRI of the head to try to find cause of headaches.

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11/16/99 R. 576	Covenant Clinic	Phone Call	Pt's counselor called and would like to try Pt on Trazodone for sleep. Rx for Trazodone.
11/16/99 R. 736	Waverly Municipal Hospital Stephen Frazier, M.D.	Portagram	Impression: No radiographic evidence of obstruction of the Porta-Cath.
11/17/99 R. 576	Covenant Clinic	Medication Refill	Refilled Imitrex
11/18/99 R. 644-45	Cedar Valley Medical Specialists, P.C. Suresh Reddy, M.D.	Abnormal liver enzymes	Pt seen for evaluation of abnormal liver enzymes and abnormal intraoperative cholangiogram. <u>Impression:</u> 1. Elevated liver enzymes with liver biopsy showing fatty liver. Intraoperative cholangiogram apparently was abnormal, showing some strictures in the bile ducts, suggestive of P.S.C. <u>Plan:</u> Obtain intraoperative cholangiogram films and have pathologist review liver biopsy slides to see if there is any evidence of P.S.C.
11/21/99 R. 646-47	Waverly Municipal Hospital D. J. Rathe, D.O.	Achy; body sweats; headache; increased ostomy output	Pt has been ill since 11/17, with increased watery output of colostomy as soon as she drinks something. It has slowed down over the last two days, but today she is quite achy and has had body sweats. She feels cold and nauseated and has a headache. <u>Impression:</u> 1.

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			Diarrhea. 2. Myalgias. 3. Sweats. <u>Plan</u> : Continue oral rehydration; may start small amounts of food; may take Tylenol for aches and pains.
11/24/99 R. 648-49	Covenant Medical Center Robert Federhofer, D.O.	Pinpoint, sharp, burning pain	Pt's chief complaint is pinpoint, sharp, burning pain, worse with palpation, over area that would be approximately the distal caudad 1 cm of the surgical scar. Pain started when staples were removed after cholecystectomy done a month ago. <u>Assessment</u> : Scar neuroma along intercostal nerve. <u>Plan</u> : Pt will undergo a series of intercostal nerve blocks starting at the cutaneous portion and trapped in the nerve. <u>Procedure</u> : Betadine prep. Injected Marcaine.
11/27/99 R. 575, 599	Covenant Clinic Lee Fagre, M.D.	Vomiting, diarrhea, body pain, fever, chills, sweats, difficulty urinating	<u>Assessment</u> : Possible sepsis. <u>Plan</u> : Recommended Pt go to the hospital and get some out-patient lab work done.
11/27/99 thru 11/29/99 R. 651	Waverly Municipal Hospital R. L. Skierka, M.D.	Urinary tract infection, gastroenteritis	Pt was admitted for rehydration. Pt was discharged home and is to continue her meds except for Ciprofloxacin. Follow up with Dr. Reddy.

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12/01/99 R. 650	Covenant Medical Center Robert Federhofer, D.O.	Follow-up re neuroma along intercostal nerve	Pt shows marked improvement with initial injection of intercostal nerve branches at the scar. The area is less sensitive to touch, but Pt has burning pain with more aggressive palpation and compression. Treated with Neurontin. <u>Procedure</u> : Injected lateral distal portion of the scar and intercostal nerve with Marcaine and Aristocort.
12/06/99 R. 652	Covenant Clinic Roger Skierka, M.D.	Referral	Pt is referred to Dr. Reddy for evaluation and treatment of persistent diarrhea.
12/07/99 R. 575	Covenant Clinic	Left third finger	Pt complaints of pain in her left third finger. She is unable to bend it. She also has left hip pain with radiation down laterally. No treatment notes.
12/08/99 R. 653	Cedar Valley Medical Specialists. P.C. Suresh Reddy, M.D.	Evaluation re diarrhea and increased ostomy output	Pt is referred for evaluation of profuse diarrhea and increased output from her ostomy since her gallbladder surgery. <u>Impression</u> : 1. Increasing output from the ileostomy probably related to recent cholecystectomy causing some post-surgical diarrhea. 2. Abnormal intraoperative

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			cholangiogram suggestive of possible sclerosing cholangitis but films are not of high quality to make a definitive diagnosis. <u>Plan</u> : Continue Metamucil and Tincture of Opium to control diarrhea. Take Pedialyte to prevent dehydration. Recommended Pt have a formal ERCP to obtain a better cholangiogram picture to make a definitive diagnosis whether she has sclerosing cholangitis or not.
12/10/99 R. 655-56	Allen Memorial Hospital Suresh Reddy, M.D.	ERCP	Postoperative diagnosis: 1. Normal pancreatic duct. 2. Normal extrahepatic biliary system. 3. Multiple strictures in the intrahepatic duct suggestive of sclerosing cholangitis. Pt's liver enzymes are only mildly elevated. There are no specific meds available for this. Actigall or Colchicine will be tried.
12/10/99 R. 654	Lawrence Liebscher, M.D.	Follow-up re Abnormal liver enzymes	ERCP was performed by Dr. Reddy. <u>Impression</u> : The intrahepatic bile ducts appear diffusely narrowed with some areas of focal stricture, possibly due to under-filling, but an inflammatory process is possible. Cholangitic hepatitis is possible, although no focal areas of dilatation and only a few areas of focal

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			stricture are present, which would not be typical for sclerosing cholangitis. The extrahepatic bile ducts appear normal.

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12/14/99 R. 657-58	Covenant Clinic Roger L. Skierka, M.D.	Opinion letter	Pt has long history of ulcerative colitis. A large section of her colon was removed as a child; she has a colostomy bag to help with bowel movements. Complications include arthritis. She has a history of liver changes and recently underwent a cholecystectomy to remove her gallbladder. A liver biopsy is pending, but showed some chronic signs of change secondary to what was presumed to be ulcerative colitis. Pt suffers from diabetes mellitus and requires insulin. Pt suffers from depression and anxiety attacks. She is on an extensive amount of medicine for GI upset secondary to ulcerative colitis. "Because of her diabetic problem, arthritis and other problems associated with her ulcerative colitis we do not feel that she is capable of working outside of the home. Although she is attempting to do everything she can to maintain her own ability to function on her own, she is having a very difficult time."
12/14/99 R. 667-68	Mayo Clinic Herschel A. Carpenter, M.D.	Pathology report	Needle biopsy of live: "Consistent with small duct primary sclerosing cholangitis, stage 2-3."

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12/31/99 R. 669	Waverly Municipal Hospital Roger L. Skierka, M.D.	Sweating, cough	Normal chest X-ray
01/11/00 R. 670	Waverly Municipal Hospital A. E. Delbridge, M.D.	Back and lower extremity pain	Pt underwent facet injection at L4-5 bilateral, L5-S1 bilateral, and an epidural injection under fluoroscopic control.
04/05/00 R. 671-72	Waverly Municipal Hospital Traci Skierka, M.D.	Vomiting, diarrhea	Pt comes in the hospital after 24 hours of vomiting and straight water from her ostomy bag. <u>Assessment/ Plan</u> : 1. Vomiting and diarrhea with dehydration. Pt was placed in an observation bed and was given a couple of liters of fluid.
04/06/00 R. 673-74	Waverly Municipal Hospital Roger L. Skierka, M.D.	Pre-surgical work-up	Pt approved for surgery with general anesthesia on 04/10/00.
04/10/00 R. 675	Waverly Municipal Hospital Dawn Morey, D.O.	Rectal pain and drainage	Procedure: Rectal exam under anesthesia and curettage of abnormal mu- cosa versus granulation tissue.
04/19/00 R. 676	Cedar Valley Mental Health Center Pat Jebe, LMHC	Opinion letter	Pt has diagnosis of depres- sion; treated with Paxil and Trazodone. Pt's "numerous ailments require that she take a number of meds, is fre- quently seen by various medical health professionals and she has needed to be hospitalized a number of times over the recent year or so. Though [Pt] has insur-

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			<p>ance, she has a high deductible, and her co-payment is more than she can afford, as is her high monthly insurance bill. She cannot always afford to buy her meds, and she tends to go without them as well as postponing needed appointments with medical personnel, as she cannot afford to pay for these services. Due to [Pt's] numerous chronic illnesses and her limited income, I feel that she should seek out assistance through SSI income. She cannot possibly continue to shoulder the medical bills that she will certainly face in the future, and the stress of this situation undermines her mental health. I understand that [Pt] is to have a hearing regarding her SSI benefits in a few weeks, and it is my hope that she will be eligible."</p>
04/19/00 R. 677-78	Covenant Clinic Roger L. Skierka, M.D.	Opinion letter	<p>Pt has a long history of chronic medical problems. Because of her ulcerative colitis, Pt is at increased risk for complications such as liver failure. Her liver function tests have recently gone up showing she is having some signs of complications with her liver. Even after</p>

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			<p>having had her gallbladder removed, the gastroenterologist, Dr. Reddy, felt Pt eventually would develop more liver complications secondary to ulcerative colitis. Pt's liver function tests are monitored on a six-month basis. Pt also has Type I diabetes and she is suffering from depression. "Because of her medical problems she is on a lot of different medicines at this time. She has frequent physician visits both to primary care physicians such as myself and to specialists such as the surgeon." Pt recently had a cyst removed in her abdominal region and is starting to develop arthritis; both are complications of chronic ulcerative colitis. Pt has a subsequent risk of developing cancer associated with the ulcerative colitis. Pt also helps care for her mother, which is burdensome, but she seems to be maintaining okay. "In light of her many medical problems and the need to frequently visit physicians for these problems it is felt that any assistance that can be provided for this patient would be greatly appreciated by both the medical profes-</p>

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			<p>sionals and also by the patient. The medicines she takes are not inexpensive and some of them are not provided by drug companies for free. Although we can supply her with some medicine on an infrequent basis without cost to the patient, most do have to be provided through a pharmacy. She is also subsequently unable to do most types of manual labor due to the arthritis and the chronic problems that she suffers from. It is therefore felt that, again, if any assistance can be administered for this patient, it would be greatly appreciated. It will also help reduce the stress in her life which will also help reduce the amount of time that she does have to seek medical attention. In the long run I think it will actually help save money and also help this patient.”</p>
08/23/00 R. 681-86	Paul From, M.D.	Answers to interrogatories with attached summary	<p>Pt has severe impairments, but no specific impairment meets the listing criteria. “There is no documentation that the impairment is disabling other than for statement[s] from 2 attending physicians. These opinions differ somewhat from listed</p>

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			<p>objective criteria in previous evaluations.” “On December 10, 1999, Dr. Reddy did find evidence of sclerosing cholangitis. Symptoms and findings seem to change somewhat in 1999.” Pt’s problems “appear to be those of a socioeconomic nature rather than true medical problems.” “There are very few laboratory findings although the events of multiple problems do[] continue and increase throughout these documents.” Opines if Pt were in compliance with prescribed treatment, her ostomy output would be “under fairly good control.” “However, the development of depression and then the cholangitis later occurred. The attending physicians do not comment upon non-compliance, but this is readily apparent in other documents in [the Record].”</p>
11/01/00 R. 687-88	Covenant Clinic Roger L. Skierka, M.D.	Opinion letter	<p>“We have been making an attempt to obtain Social Security benefits for this patient due to her chronic medical problems which have resulted in her disability to perform most activities of daily living.” Per Pt’s report, she used to be able to manage</p>

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			<p>a day care setting with several children. At this point she has a very difficult time managing 2-3 children for a short period of time. Pt's past medical history is significant for ulcerative colitis and significant number of surgical procedures done. Pt has type I diabetes mellitus, hypertension, history of dysmenorrhea, history of migraine headaches, history of ovarian cysts; and degeneration of her spine due to arthritis, most likely from the ulcerative colitis. Pt has abnormal liver function due primarily to ulcerative colitis. Pt suffers from significant depression and has chronic pain. "It is my medical opinion that this woman does have significant disability due to her chronic medical problems. Taken individually, I am sure most people could handle hypertension without any problem or diabetes without any problem or depression. Unfortunately, this woman has a combination of many medical problems that have caused a significant debilitation."</p>